

7448  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b. <u>2342.2</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> d. STREET ADDRESS <u>4 Sixth Street</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>Barley</u> Last <u>Barley</u>		4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 3, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>2</u> Hours <u>1</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House-work</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM CLARK</u>	
14. MOTHER'S MAIDEN NAME <u>MARTHA</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Ruth Coulbourne - Pocomoke Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Cecum</u> 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>153.0</u> DUE TO (c) <u>153.0</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>153.0</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5:15</u> , 19 <u>60</u> , to <u>6:12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6:12</u> , 19 <u>60</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. A. Briele</u>		DATE SIGNED <u>6.13.60</u>	
PHYSICIAN'S NAME (Type) <u>H. A. Briele</u>		ADDRESS (Street, city or town, state) <u>Salisbury Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-19-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Halls Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Krous</u>	
ADDRESS <u>New Church, Md.</u>		DATE <u>JUN 20 '60</u>	

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)  
15M 9/58

1910

TO THE HONORABLE THE COMMISSIONER OF AGRICULTURE  
ALBANY, N. Y.

SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the application for a license to sell and distribute the fruit of the State of New York.

I am sorry to hear that you have been unable to obtain the necessary license. I am sure that you will be able to obtain it in the future.

I am, Sir, very respectfully,  
Yours truly,  
J. C. [Signature]

1

## CERTIFICATE OF DEATH

Reg. 07433

7449

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 day</u> <u>X</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. STREET ADDRESS <u>Route # 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fletcher W. Barkley</u>				4. DATE OF DEATH Month Day Year <u>June 25 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-7-1893</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John W. Barkley</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Barkley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>1917</u>				16. SOCIAL SECURITY NO. <u>220-01-8622</u>			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>C.V. Accident (Right Hemiplegia)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO <u>1 1/2 years</u> (c) <u>36 hours</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus; Arteriosclerosis</u>							
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>				20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20d. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 1, 1960</u> to <u>June 25, 1960</u> that I last saw the deceased alive on <u>June 25, 1960</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Herbert Sembly</u> M.D.				ADDRESS (Street, city or town, state) <u>400 E. Church St. Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly</u>				DATE SIGNED <u>6/28/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6-28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Flower Hill Cem</u>	
22d. LOCATION (City, town, or county) <u>Eden, Ind.</u>							
23. REGISTRAR'S SIGNATURE <u>Thornton B. Selley</u>				24a. REC'D BY REGISTRAR <u>DATE 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Guthrie L. Hoad</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 07434

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>H.</b> Last <b>Beck</b>		4. DATE OF DEATH Month <b>6</b> Day <b>26</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 30, 1878.</b>
9. AGE (In years last birthday) yrs. <b>81</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>26</b>	IF UNDER 24 HRS. Hours <b>26</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bank Clerk Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>National Bank</b>	11. BIRTHPLACE (State or foreign country) <b>Wheeling, West Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Beck</b>	
14. MOTHER'S MAIDEN NAME <b>Frances Geiger</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>Mr. J.W. BECK (Nephew)</b>		17. ADDRESS <b>311 Park Heights Ave Salisbury, Maryland,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Embolus to left Femoral Artery</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov</b> , 19 <b>59</b> , to <b>June</b> , 19 <b>60</b> , that I lost saw the deceased alive on <b>26 June</b> , 19 <b>60</b> , and that death occurred at <b>505A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.		ADDRESS (Street, city or town, state) <b>407 Camden Ave Salisbury Md</b>	
PHYSICIAN'S NAME (Type) <b>Earl L. Royer</b>		DATE SIGNED <b>6-26-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 28/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William T. H. H. H.</b>		24a. REC'D BY REGISTRAR <b>Piedmont, W.Va.</b>	
24b. REGISTRAR'S SIGNATURE <b>William T. H. H. H.</b>		DATE <b>JUN 28 '60</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED  
JAN 10 1964

7430

OFFICE OF THE  
DIRECTOR

1964

MEMORANDUM FOR THE DIRECTOR  
SUBJECT: [Illegible]

1. [Illegible]

2.

[Illegible]

3. [Illegible]

[Illegible]

4. [Illegible]

[Illegible]

[Illegible]

[Illegible]



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07435

7451

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Princess Anne</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>Greenwood Section</b>	
3. NAME OF DECEASED (Type or print) <b>Ralph</b> <b>Bray, Jr.</b>		4. DATE OF DEATH <b>6-11-60</b> <b>19</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1935</b>
9. AGE (In years last birthday) <b>25</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Saw mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ralph Bray, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clara Bray</b>		Address <b>Bayview, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bullet wound of aorta</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shot by common law wife-Lula Hayward.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>  <b>"</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by common law wife-Lula Hayward.</b>	
20c. TIME OF INJURY Hour <b>2:20</b> a.m. p.m. Month, Day, Year <b>6-11-60</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Princess Anne Somerset Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Earl L. Royer</i>		DATE SIGNED <b>6-21-60</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		Address (Street, city, town, county, state) <b>407 Gandon Ave. Salisbury, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 18, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Antioch Baptist</b>	22d. LOCATION (City, town, or country) (State) <b>Treherneville, Va.</b>
23. FUNERAL DIRECTOR <b>Edgar Wharton - Accomac, Va.</b>		24a. REC'D BY REGISTRAR <b>JUN 22 '60</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Fraws</i>			

MEDICAL CERTIFICATION





## CERTIFICATE OF DEATH

07436  
Reg. Dist. No.

7452

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY</u>	
c. LENGTH OF STAY IN 1b <u>4 DAYS</u>		23422	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>		d. STREET ADDRESS <u>618 WALNUT STREET</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM C. Bunting</u>		4. DATE OF DEATH Month Day Year <u>June 10 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 14 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCKING</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>SLYVESIER BUNTING</u>		14. MOTHER'S MAIDEN NAME <u>GENEVIE HILL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW #1</u>		16. SOCIAL SECURITY NO. <u>231-01-4394</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>161X</u> DUE TO <u>Carcinoma of rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Esophagus</u> DUE TO <u>1-2 1/2</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6:10</u> , 19 <u>60</u> , to <u>6:10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6:10</u> , 19 <u>60</u> , and that death occurred at <u>120</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. H. Briele</u> M.D.		DATE SIGNED <u>6-10-60</u>	
PHYSICIAN'S NAME (Type) <u>H. H. Briele</u>		ADDRESS (Street, City or town, state) <u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-12-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN</u>	22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Watson</u> ADDRESS <u>Pocomoke Md.</u>		24. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
24b. REC'D BY REGISTRAR <u>JUN 14 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1870

STATE OF NEW YORK

1870

IN SENATE,  
January 10, 1870.

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE, MAY 1, 1869.

ALBANY: PUBLISHED BY THE STATE OF NEW YORK, 1870.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7453

1. PLACE OF DEATH  
a. COUNTY Wicomico MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury 3 1/2 hrs.  
c. LENGTH OF STAY in lb  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission)  
a. STATE Maryland Worcester  
b. COUNTY Worcester  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pocomoke City  
d. STREET ADDRESS Route # 2

3. NAME OF DECEASED (Type or print) Brauddus F. Byrd  
4. DATE OF DEATH 6-1-60 19  
5. SEX M W WIDOWED DIVORCED Sept. 15, 1904  
6. COLOR OR RACE W NEVER MARRIED 58  
7. MARRIED NEVER MARRIED 58  
8. DATE OF BIRTH Sept. 15, 1904  
9. AGE (In years last birthday) 58  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter  
10b. KIND OF BUSINESS OR INDUSTRY Building  
11. BIRTHPLACE (State or foreign country) Maryland  
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Alonzo D. Byrd  
14. MOTHER'S MAIDEN NAME Florence Godwin

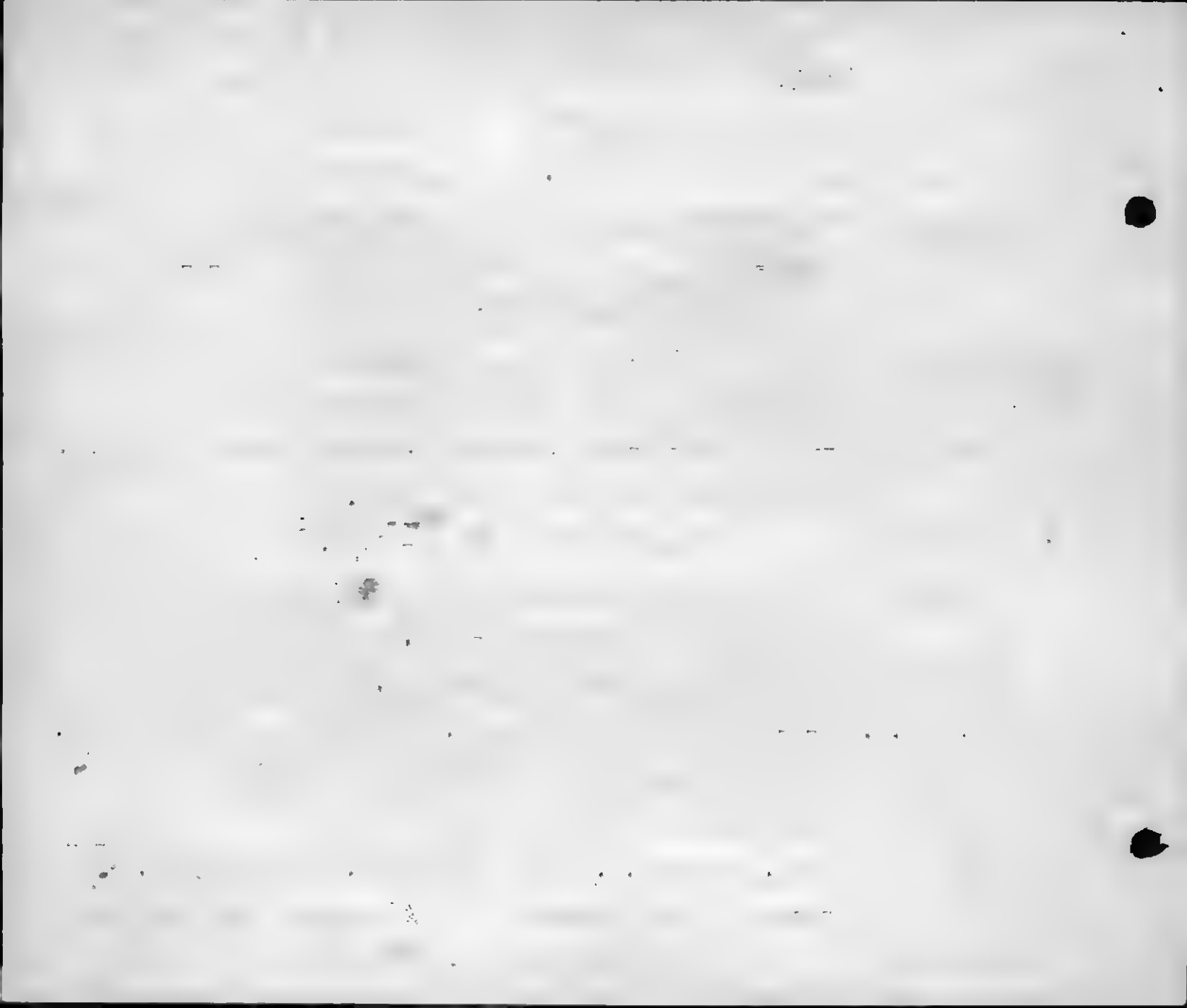
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No  
16. SOCIAL SECURITY NO. 218-14-4007  
17. INFORMANT Mrs Lola T. Byrd, Pocomoke City, Md.  
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Sub-dural hemorrhage- right.  
DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured base of skull- left.  
DUE TO  
(c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured ribs with hemothorax-left.  
19. WAS AUTOPSY PERFORMED? YES X NO ☐

20a. EXTERNAL CAUSE OF DEATH  
PRIMARY OR CONTRIBUTING CAUSE OF DEATH. Fell from ladder at work.  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year 1:30 P.M. 6-1-60  
20d. INJURY OCCURRED While at work X Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At work.  
20f. (City or town) (County) (State) Chincoteague Va.

21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes ☐ Accident X Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Earl L. Royer M.D. CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) Earl L. Royer, M.D. ASSISTANT MEDICAL EXAMINER ☐  
DATE SIGNED 6-2-60  
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial 22b. DATE THEREOF 6-4-60 22c. NAME OF CEMETERY First Baptist 22d. LOCATION (City, town, or country) (State) Pocomoke City, Maryland

23. FUNERAL DIRECTOR Henry H. Watson ADDRESS Pocomoke City, Md.  
24a. REC'D BY REGISTRAR JUN 6 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kenna



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7454

07438

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>4 Mo. 3 Days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u> d. STREET ADDRESS <u>1</u> ----- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Herman</u> Middle ----- Last <u>Collier</u>		<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>18</u> Year <u>19 60</u>					
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>February 1, 1874</u>	<b>9. AGE</b> (In years last birthday) <u>86</u> yrs	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>							
<b>13. FATHER'S NAME</b> <u>George Collier</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Wainwright</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>-----</u>		<b>17. INFORMANT</b> <u>Hospital Records -- Salisbury, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Reticulum Cell -- Sarcoma</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19____	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/15/</u> 19 <u>60</u> <b>to</b> <u>6/18/</u> 19 <u>60</u> <b>that (I) (we) last saw the deceased alive on</b> <u>6/18/</u> 19 <u>60</u> <b>and that death occurred at</b> _____ <b>M, from the causes and on the date stated above</b>							
<b>22a. SIGNATURE</b> <u>Lee I. Lawry</u>		<b>22b. DATE</b> <u>7:35 A.M.</u>	<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Lee I. Lawry</u>				
<b>22d. ADDRESS</b> <u>Salisbury, Maryland</u>		<b>22e. DATE SIGNED</b> <u>June 18, 1960</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>6/20/60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Turners Cem.</u>		<b>23d. LOCATION (City, town, or county)</b> <u>Nanticoke, Md.</u>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>E. J. Messing, Bivall, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>JUN 21 '60</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>			

M

I

19





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



X

1

<div> <div> <div>7491</div> <div>Item 23b, Film 6-20-60</div> </div> <div> <div>MARYLAND STATE BOARD OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</div> </div> <div> <div>07439</div> <div>07/13/60 iwk</div> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>				c. LENGTH OF STAY IN 1b <b>50 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Delmar</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>301 Chestnut</b>				d. STREET ADDRESS <b>301 Chestnut</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Mary</b> Middle <b>Ethel</b> Last <b>Cox</b>				<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>10th</b> Year <b>1960</b>							
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct. 15, 1881</b>		<b>9. AGE</b> (In years last birthday) <b>78</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At Home</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>Noah James Brown</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Louisa Oliphant</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO</b> <b>None</b>		<b>17. INFORMANT</b> <b>Lee H. Cox, Delmar, Md.</b>				Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of urinary bladder</b> DUE TO <b>181.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with local extension and general metastases</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month. Day. Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		(County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>3/1, 1960</b> <b>to death</b> , 19____, that (I) (we) last saw the deceased alive on <b>6/12, 1960</b> , and that death occurred at <b>6:30 P.</b> from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <b>Eust M. Larmore</b>				<b>M.D.</b>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>6/11/60</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>P. M. LARMORE</b>				<b>22d. ADDRESS</b> <b>DELMAR, DEL.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>June 12, 1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>First Methodist</b>				<b>23d. LOCATION</b> (City, town, or county) (State) <b>Delmar, Del.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. S. Marvel Co - Delmar, Del.</b>						<b>ADDRESS</b>		<b>25a. REC'D BY REG-STRAR</b> <b>DATE JUN 13 '60</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>	



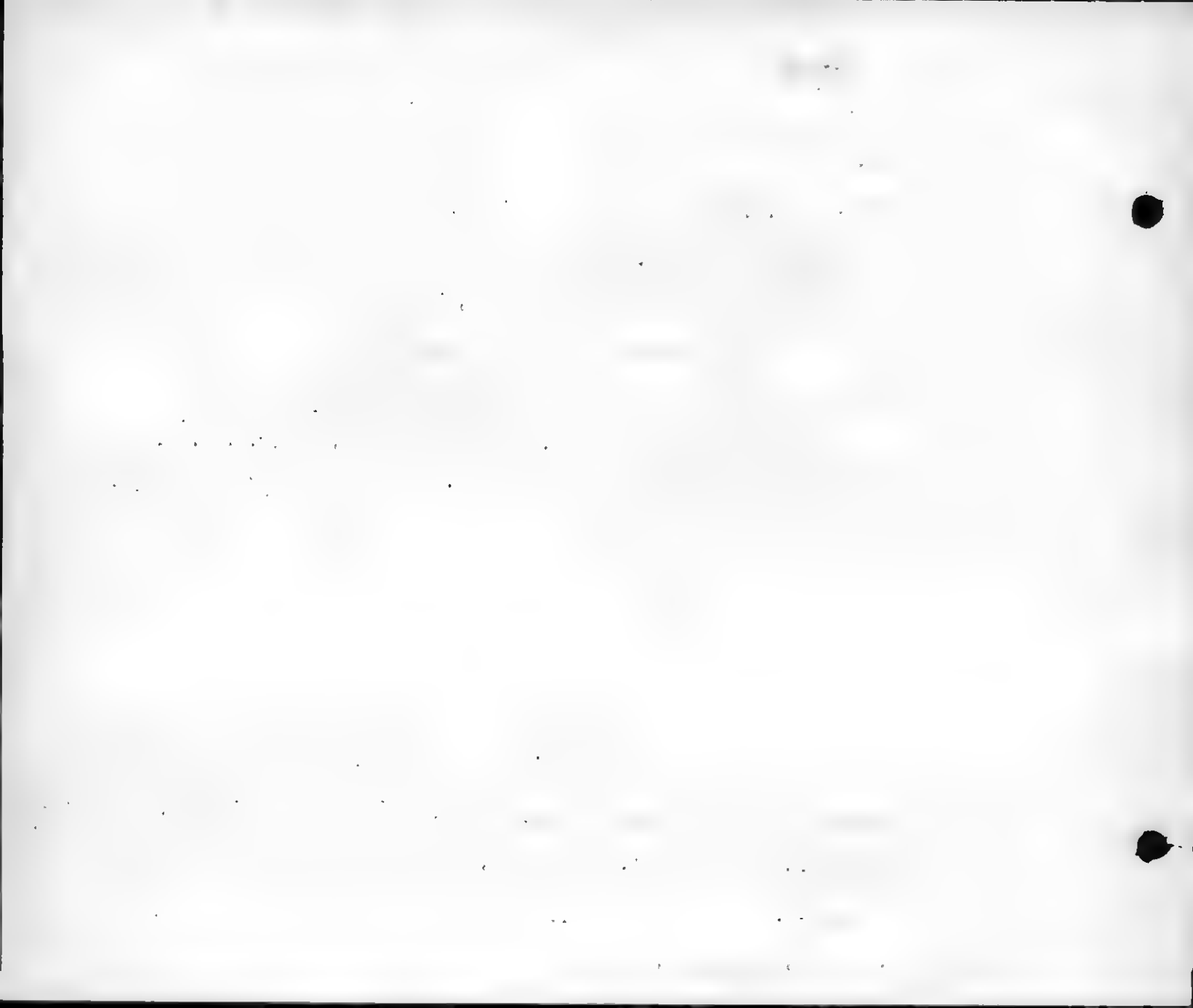
CERTIFICATE OF DEATH

Reg. Dist. No. 07440

7492

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nanticoke</b>				c. LENGTH OF STAY IN 1b <b>2 Mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Nanticoke (Pvt. Home)</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
e. STREET ADDRESS <b>Route #1</b>							
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>E. Dashiell</b> Last				4. DATE OF DEATH Month <b>6</b> Day <b>27</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>AA</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 2, 1885</b>	
9. AGE (In years lost birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>5</b> Hours <b>15</b> Min.		IF UNDER 24 HRS Months <b>7</b> Days <b>5</b> Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George Dashiell</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Gattis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT 213 Broad St. Mr. Thurman Dashiell, Beverly, N. J.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix Uteri</b> 177X DUE TO (b) <b>4 yrs.</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 Mar. 1960</b> to <b>26 June 1960</b> at I last saw the deceased alive on <b>19</b> and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>NANTICOKE, MD</b> DATE SIGNED <b>6/29/60</b>							
ACTUAL SIGNATURE <b>Richard H. Saunders MD</b>							
PHYSICIAN'S NAME (Type) <b>Richard H. Saunders, MD. Nanticoke, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-30-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Family Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>White Haven Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Thornton B. Jolley, Salisbury, Md</b>				24a. REC'D BY REGISTRAR <b>DATE JUN 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Clifton S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



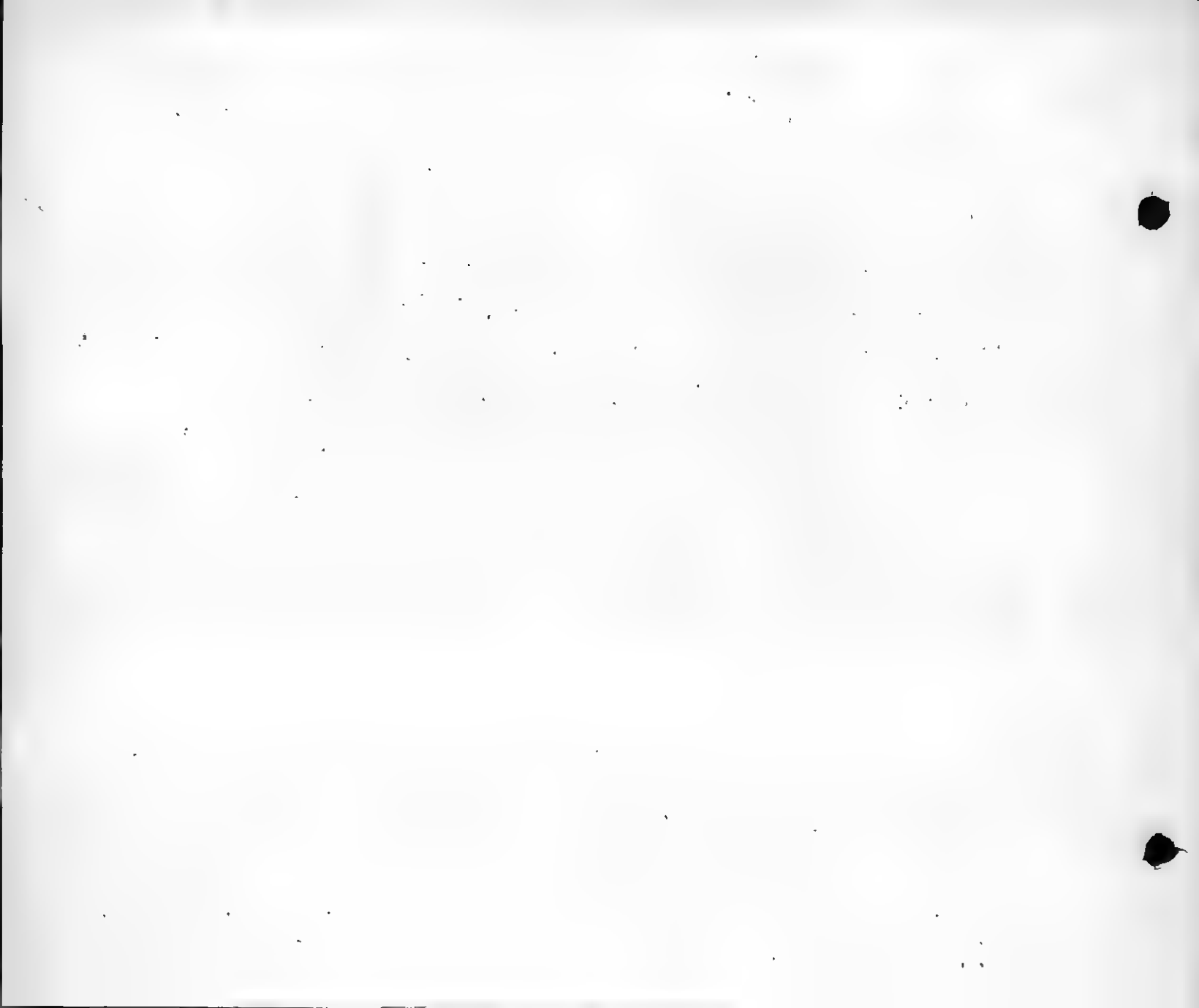
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>3 mo.</u> X <u>Fruitland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADA LAVINIA Dusharoon</u>		4. DATE OF DEATH Month Day Year <u>June 11 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1888</u> AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Monie, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Henry Price</u>		14. MOTHER'S MAIDEN NAME <u>Mary Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs. Alvin Hall, Fruitland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> <u>Degenerative Heart Disease</u> DUE TO (b) <u>unknown</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1958</u> , 19 <u>60</u> to <u>6-11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-11</u> , 19 <u>60</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6-11-60</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 14, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grace Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Vernon, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leven B. Wilson, Princess Anne, Md.</u> ADDRESS _____		24a. REC'D BY REGISTRAR <u>JUN 15 '60</u> DATE _____	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

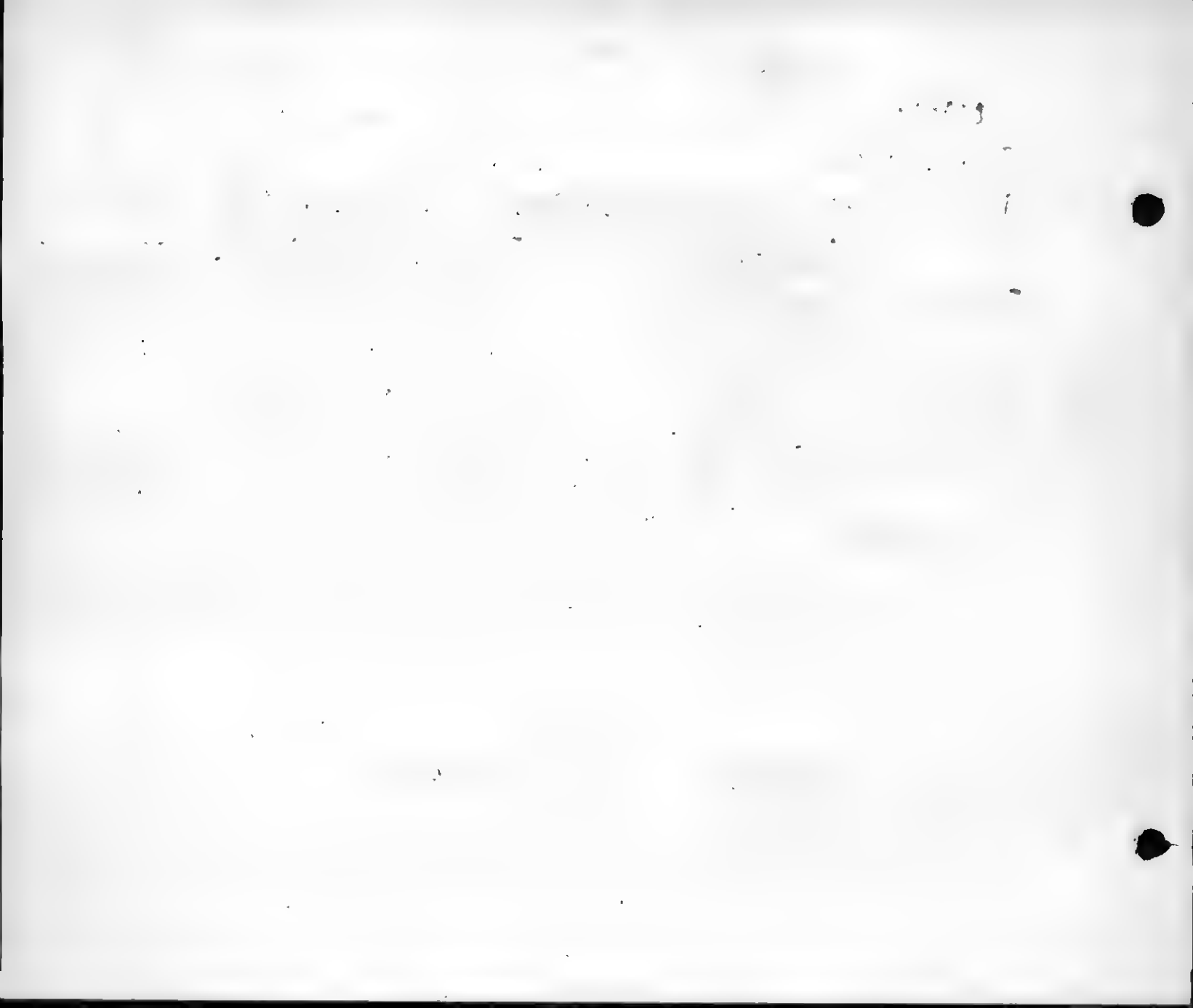
07443

7456

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> 224			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>100 6th Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Evans</u> Last <u>Evans</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 27 1891</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>	10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>JANITOR</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CALVIN EVANS</u>				14. MOTHER'S MAIDEN NAME <u>LAURA JUSTIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>220-28-1401</u>		INFORMANT <u>Sara M. Evans - Pocomoke Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobar pneumonia R.</u> DUE TO <u>Bronch pneumonia L.</u> Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic heart condition</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic heart condition</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>6/13/60</u> the deceased from <u>6/12/60</u> , 19 <u>60</u> , to <u>6/13/60</u> , that I last saw the deceased alive on <u>6/13/60</u> , and that death occurred at <u>6:30</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-18-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>				24a. REG'D BY REGISTRAR <u>JUN 20 60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kimes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO FURNISH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in line 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with forms 1 and 2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VE. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

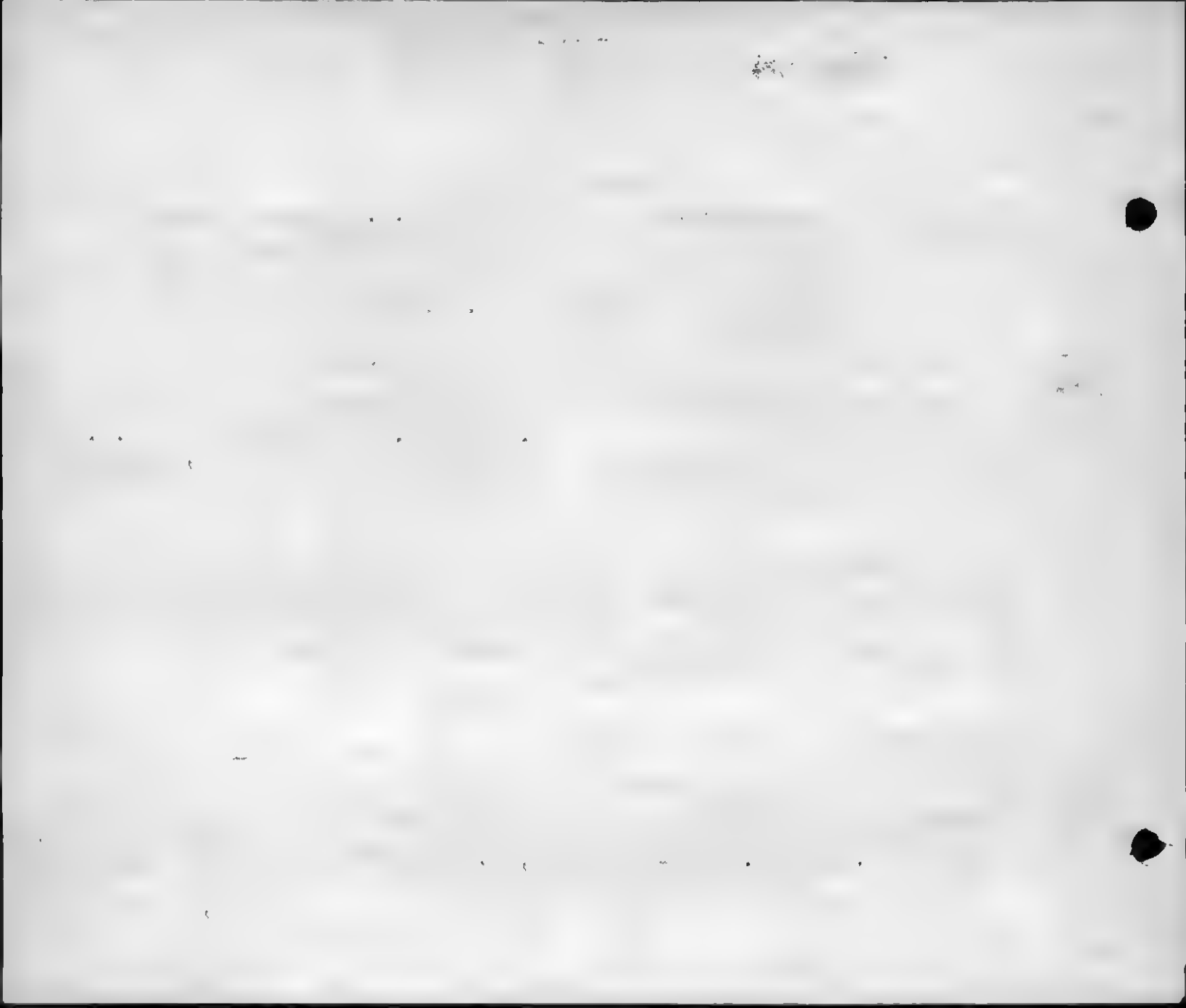
7493 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07444  
Item 8 file 6264 6-14-60 et

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Hebron</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>R.D.# 3 (Delmar Road)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Old Gravel Pit-Water Hole</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>TERRY LEE FITZGERALD</b>	4. DATE OF DEATH Month <b>June</b> Day <b>5th</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1942 Sept. 17, 1942</b>
9. AGE (in years last birthday) <b>17 yrs.</b>	IF UNDER 1 YEAR Months <b>17</b> Days <b>17</b> Hours <b>17</b>	IF UNDER 24 HRS. Months <b>17</b> Days <b>17</b> Hours <b>17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Arthur Linwood Fitzgerald</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Mason</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Arthur L. Fitzgerald (Father) R.D.#3 (Delmar Road) Salisbury, Maryland</b>	
17. INFORMANT <b>Mr. Arthur L. Fitzgerald (Father) R.D.#3 (Delmar Road) Salisbury, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>DROWNING</b> <b>129.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>129.8</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>129.8</b> DUE TO (b) <b>129.8</b> DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Swimming in gravel pit</b>			
20c. TIME OF INJURY Month, Day, Year <b>6-5-1960</b> Hour <b>6:15</b> a.m. <b>6:15</b> p.m.		20d. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Home</b>	
20e. (City or town) <b>Hebron</b>		20f. (State) <b>Wicomico</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer-Salisbury, Md.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 10/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or country) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>JUN 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH  
**SUDDEN**

DATE SIGNED  
**June 8 /1960**  
**SALISBURY**



## CERTIFICATE OF DEATH

Reg. Dist. No.

07445

7457

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Wicomico General Hospital</u>		d. STREET ADDRESS <u>510 Monticello Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY BOY FOUTTY</u>		4. DATE OF DEATH Month Day Year <u>June 24 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 24 1960</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>HAROLD ALLEN FOUTTY</u>		14. MOTHER'S MAIDEN NAME <u>EVELYN RUTH FINSTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mr. Harold A. Foutty (Father)</u> <u>Salisbury, Maryland</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 830gms)</u> DUE TO (b) <u>77 x x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>approx 1 hr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/24</u> , 19 <u>60</u> , to <u>6/24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/24</u> , 19 <u>60</u> , and that death occurred at <u>12 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C. Kolls</u>		ADDRESS (Street, city or town, state) <u>Medical Center Salisbury, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Alfred C. Kolls</u>		DATE SIGNED <u>6/24/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jun. 25, 1960</u>	<u>Wicomico Memorial Park</u>	<u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>JUN 27 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082352 XVO





TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please receive carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

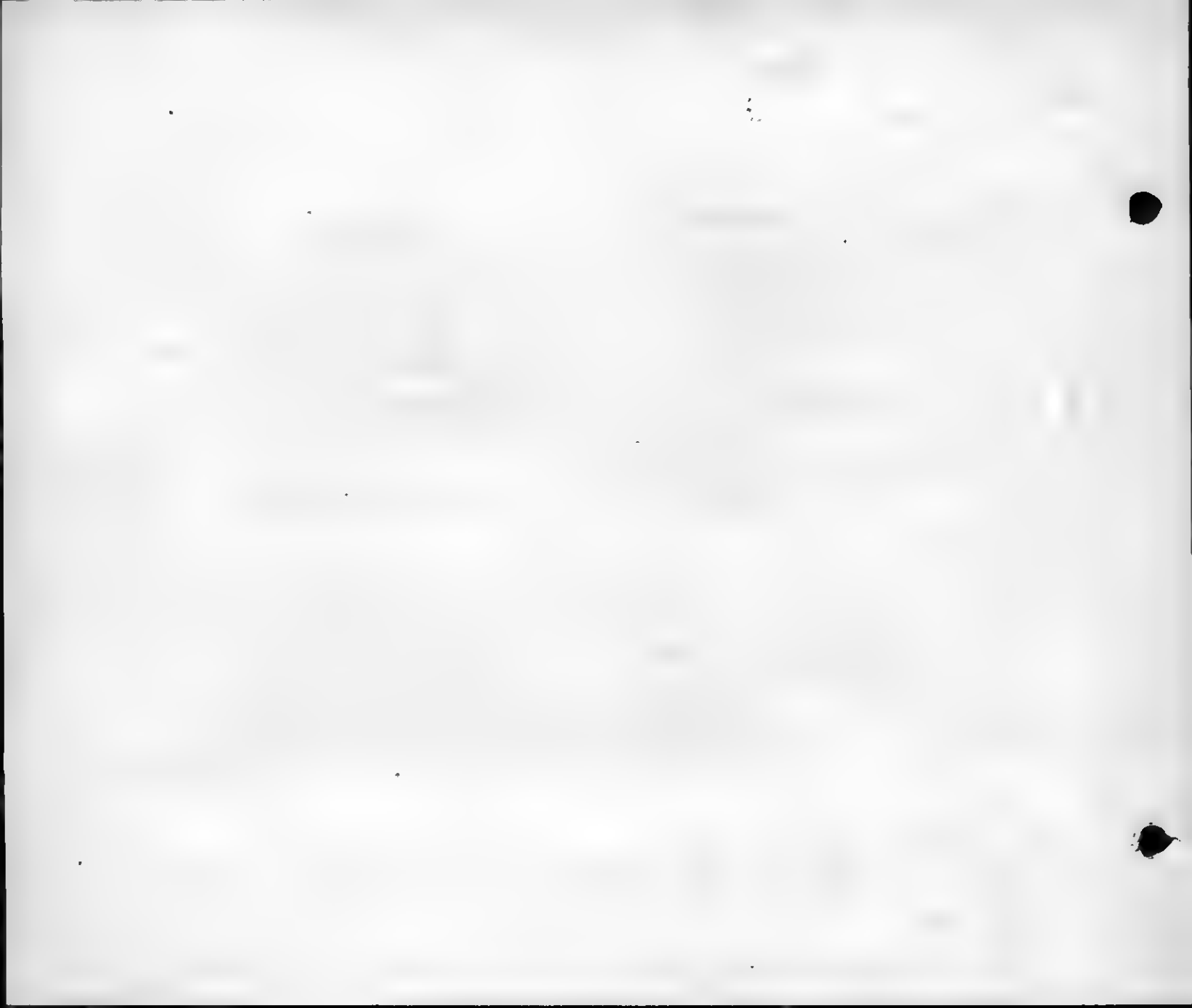
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7458

CERTIFICATE OF DEATH

07446

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>4th &amp; Park Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Frank</u> Last <u>Frank</u>				4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/5/07</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Edward Higdon</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelma Tarbutton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>213-14-6549</u>		17. INFORMANT Address <u>Hospital Records - Deer's Head Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of right breast with generalized metastasis</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/22/19 60</u> to <u>6/26 19 60</u> , that (I) (we) last saw the deceased alive on <u>6/25 19 60</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>V. Juerman</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Verner Juerman, M.D.</u>				22d. ADDRESS <u>Deer's Head Hospital, Salisbury, Md.</u>			
23a. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-29-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ridgely</u>		23d. LOCATION (City, town or county) (State) <u>Ridgely, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulais Greensboro, Md.</u>				ADDRESS <u>  </u>		25a. REC'D BY REGISTRAR DATE <u>JUN 29 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



7459

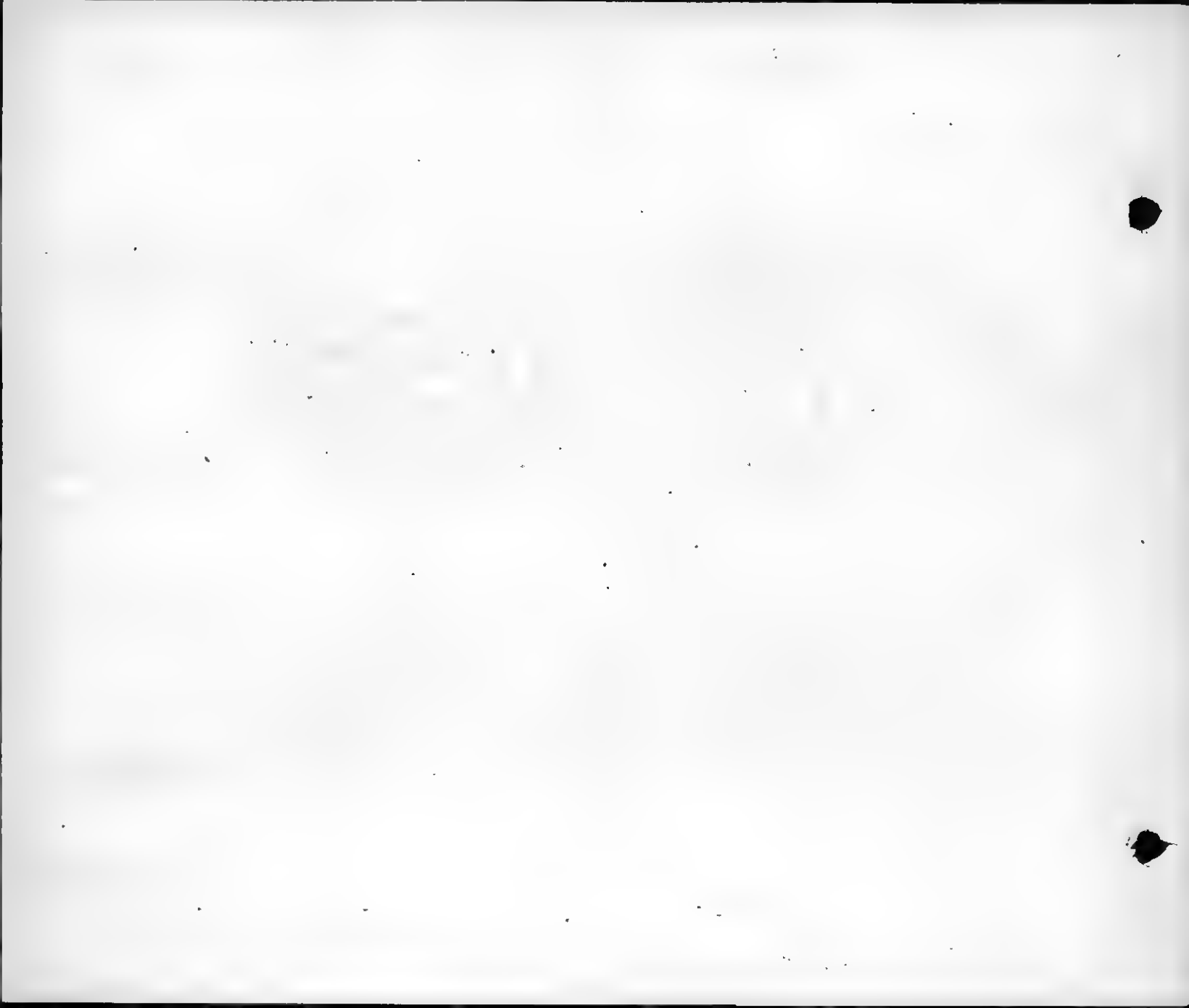
CERTIFICATE OF DEATH

Reg. Dist. No. 07447

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>11</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pennsylvan General Hospital</u>				d. STREET ADDRESS <u>Upper Hill</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hall</u>				4. DATE OF DEATH Month Day Year <u>JUNE 19 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 19-1960</u>		9. AGE (In years lost birthday) yrs <u>+</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>SALISBURY WICOMICO MID.</u>		12. CITIZEN OF WHAT COUNTRY? <u>---</u>	
13. FATHER'S NAME <u>Joseph Green</u>				14. MOTHER'S MAIDEN NAME <u>Annie Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		INFORMANT <u>Edward Hall nephew Hall</u>		Address <u>---</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atelectasis</u> DUE TO (c) <u>Prematurity - 5 months gestation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>---</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>---</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that I attended the deceased from <u>---</u> , 19 <u>---</u> , to <u>---</u> , 19 <u>---</u> , that I last saw the deceased alive on <u>---</u> , 19 <u>---</u> , and that death occurred at <u>6:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William C. Morgan M.D.</u>				ADDRESS (Street, city or town, state) <u>---</u> DATE SIGNED <u>6/19/60</u>			
PHYSICIAN'S NAME (Type) <u>---</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 20-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Centennial</u>		22d. LOCATION (City, town, or county) (State) <u>Farmington Somerset Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Howard Morgan M.D.</u> ADDRESS <u>---</u>				24a. REC'D BY REG-STRAR <u>JUN 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2052181XV0



## CERTIFICATE OF DEATH

Reg. Dist. No. 07448

7460

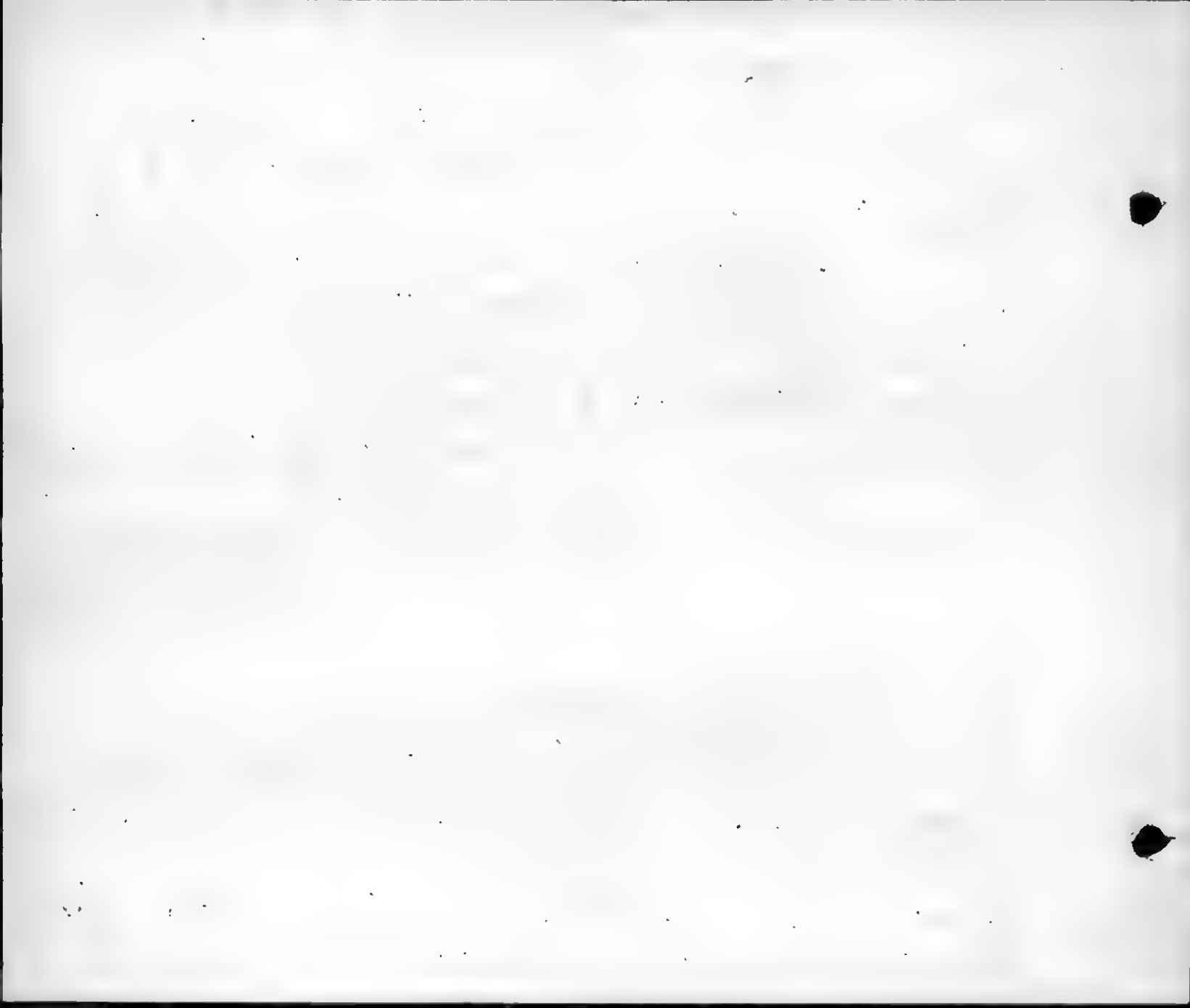
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Princess Anne</u> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>HANCOCK</u> Last <u>HANCOCK</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11 1896</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>64</u> Days <u>11</u> Hours <u>11</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Va.</u>		11. BIRTHPLACE (State or foreign country) <u>KS</u>	
13. FATHER'S NAME <u>Samuel Wessells</u>		14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>?</u>		INFORMANT <u>Iceland Hancock Princess Anne Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO (b) <u>1702</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>?</u> DUE TO (c) <u>?</u>					INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-16</u> , 19 <u>60</u> to <u>6-21</u> , 19 <u>60</u> that I last saw the deceased alive on <u>6-21</u> , 19 <u>60</u> , and that death occurred at <u>5:30</u> A. M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Wilbur A. Ellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6-21-60</u>			
PHYSICIAN'S NAME (Type) <u>Wilbur A. Ellis</u>					
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews</u>	
22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Benman</u>		ADDRESS <u>Princess Anne Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 27 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wilbur A. Ellis</u>	

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 9 File 6266 7-11-60 et

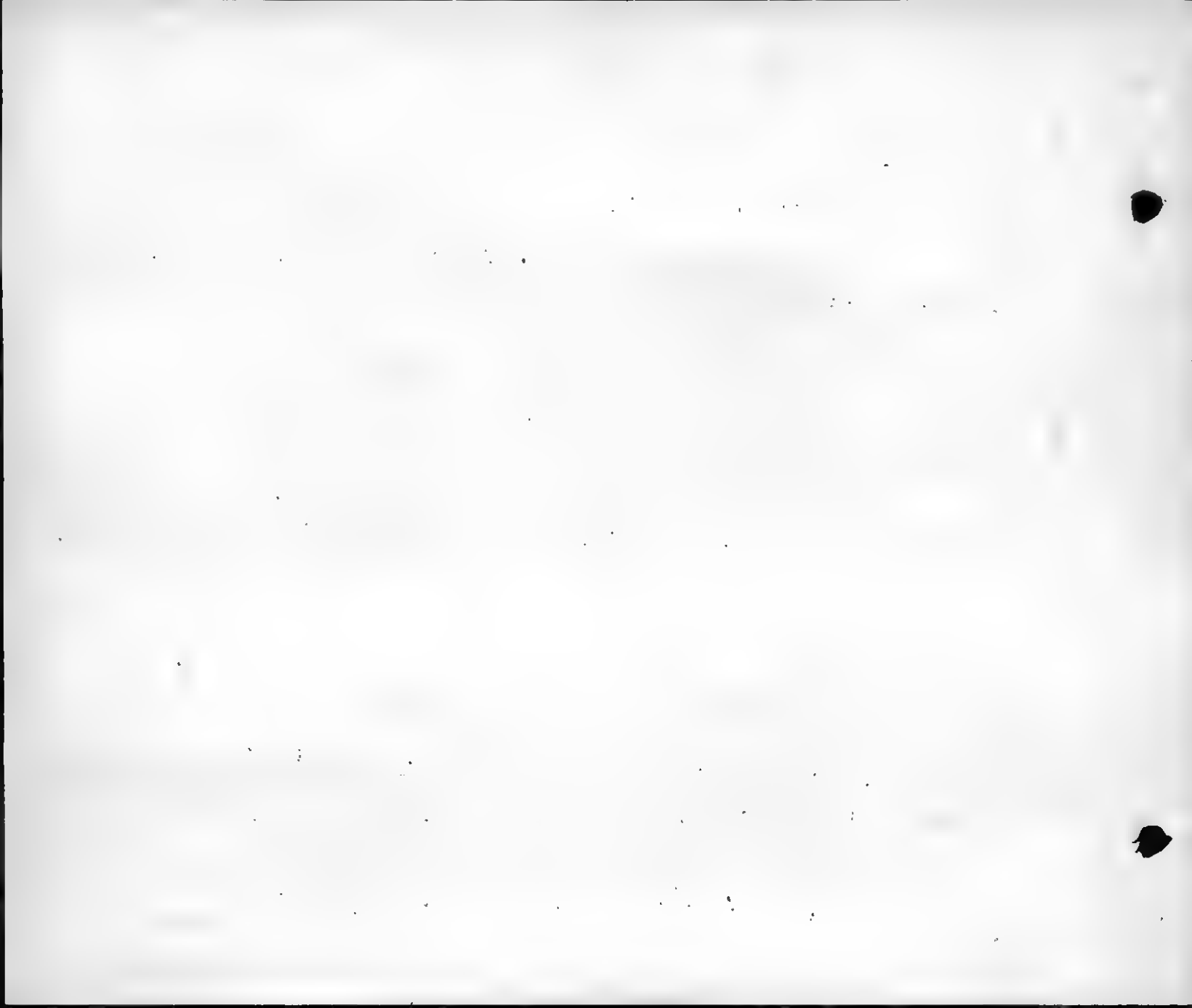
## CERTIFICATE OF DEATH

07449

Reg. Dist. No.

7461

1. PLACE OF DEATH a. COUNTY <u>Vierncomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester V</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>Darco Farms</u>	
3. NAME OF DECEASED (Type or print) First <u>BENNY</u> Middle <u>HAYES</u> Last <u>HAYES</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Approx.</u>
9. AGE (In years last birthday) yrs. <u>58</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Gen. Sen Hosp</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) <u>unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-19</u> , 19 <u>60</u> , to <u>6-21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-21</u> , 19 <u>60</u> , and that death occurred at <u>12 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>6-21-60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-24-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>V. of Md. Med. School</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR <u>JUN 28 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

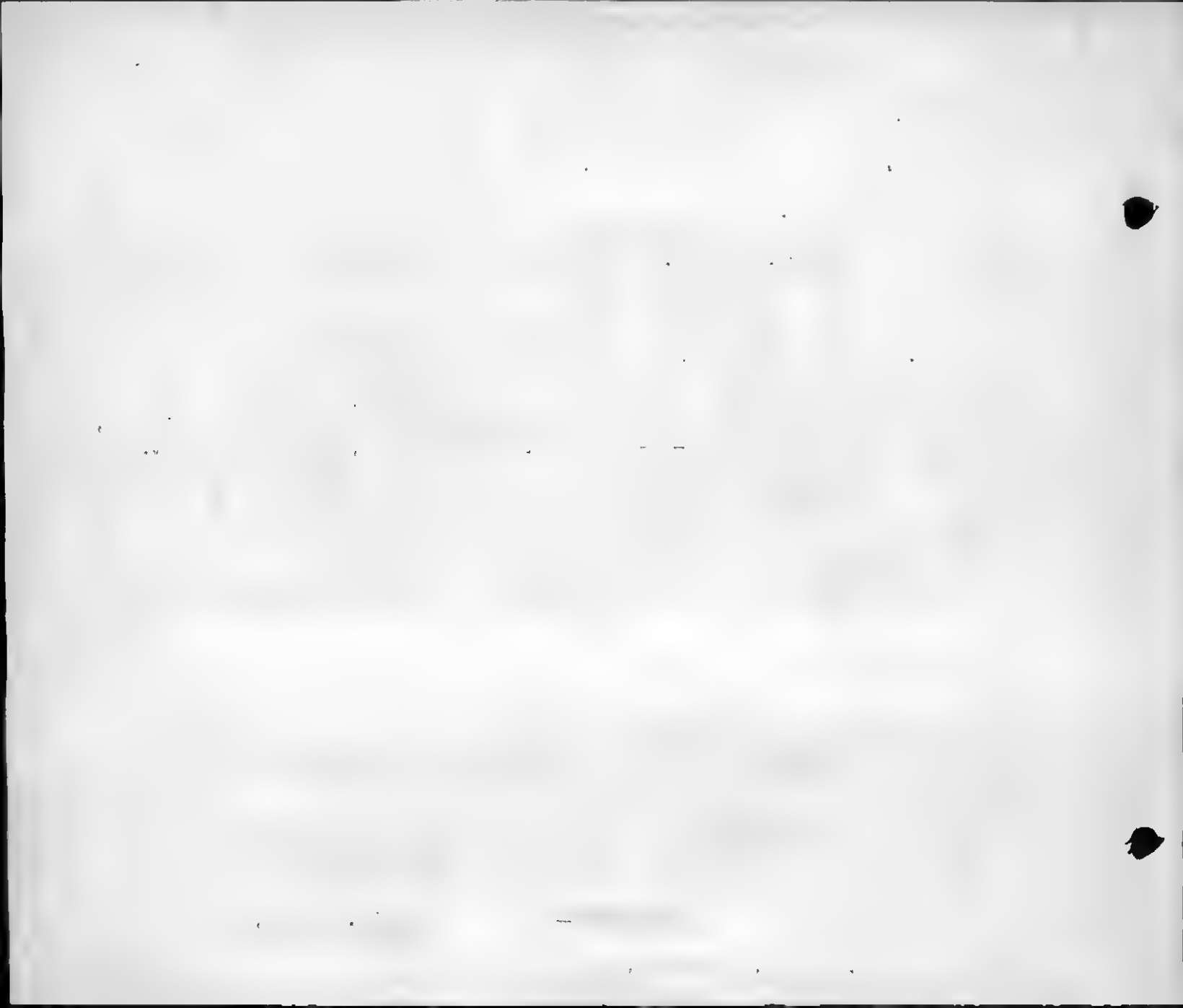
Reg. Dist. No. **07450**

**7462**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Wicomico</b></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>332 Catherine St.</b>		e. STREET ADDRESS <b>332 Catherine St</b>	
3. NAME OF DECEASED (Type or print) <b>Elmer C. Hearn</b>		4. DATE <b>DEATH</b> <b>6</b> <b>13</b> <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/6/1883</b>
9. AGE (In years last birthday) <b>76</b> yrs		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>13</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mech.</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>	
13. FATHER'S NAME <b>John Hearn</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth ?? Hearn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>221-14-7236</b>	
17. INFORMANT <b>Mrs. Esther Majors, 332 Catherine St.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20a. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20b. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/18/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cem. N. Delmar, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thernton B. Jolley, Salisbury, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 20 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

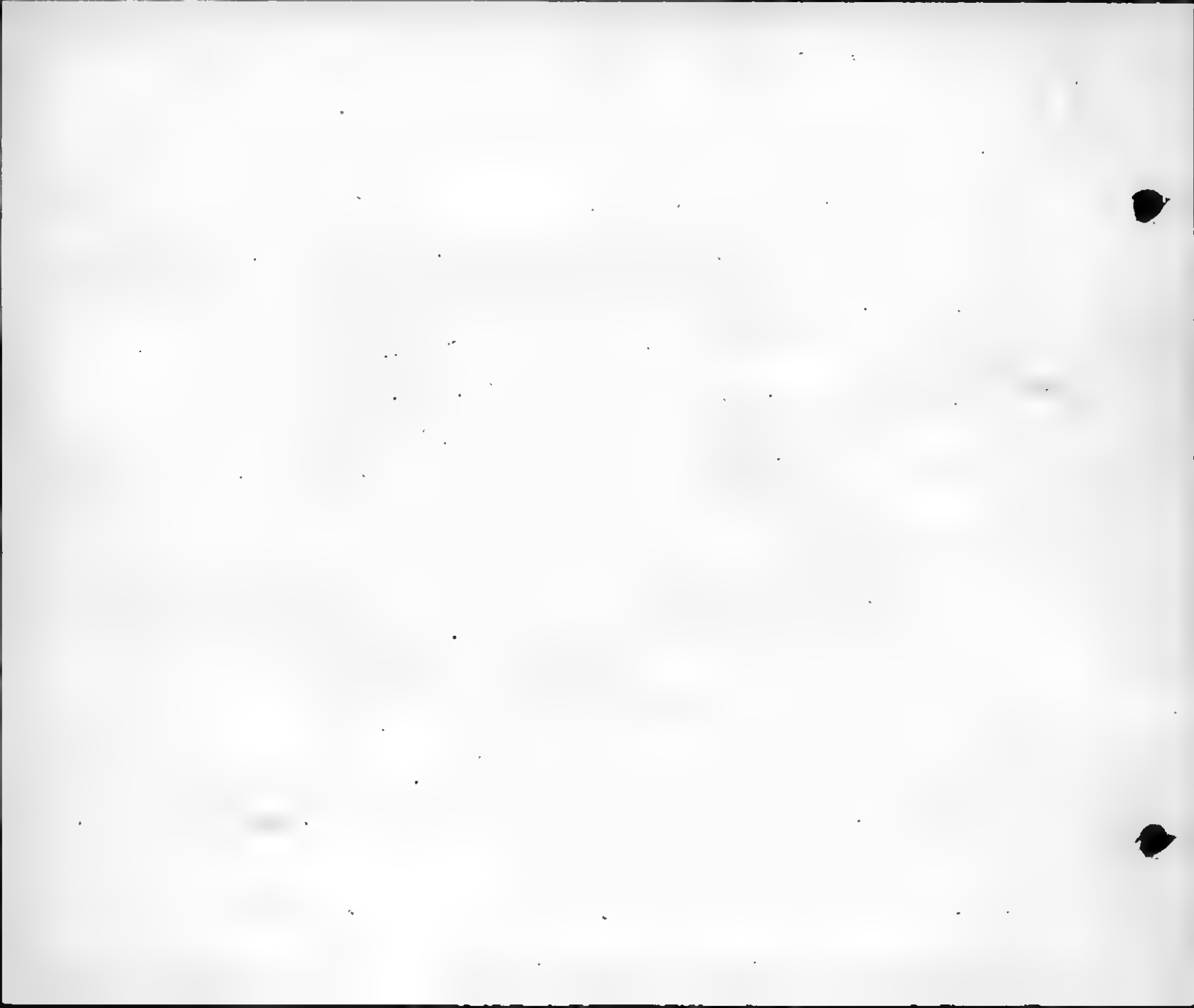
Reg. Dist. No.

7463

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>INSULA GENERAL HOSPITAL</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL (RURAL)</u> d. STREET ADDRESS <u>RD 2 4</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>EVERETT W. HEARN</u>			4. DATE OF DEATH Month Day Year <u>JUNE 27 1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 13, 1894</u>	9. AGE (In years last birthday) <u>65 yrs.</u>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>L. MARTIN HEARN</u>			14. MOTHER'S MAIDEN NAME <u>Hester Williams</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	INFORMANT Address <u>GRACE M. HEARN Laurel Del</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>54-1-0</u> DUE TO <u>Arterial thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>October</u> , 19 <u>1955</u> to <u>June 27, 1960</u> , that I last saw the deceased alive on <u>June 27, 1960</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Arthur S. Hearn</u>		M.D. <u>Salisbury Md</u>		DATE SIGNED <u>June 27, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Arthur S. Hearn</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/30/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Delmar Del.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hearn</u>			24a. REC'D BY REGISTRAR DATE <u>JUN 29 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

7494

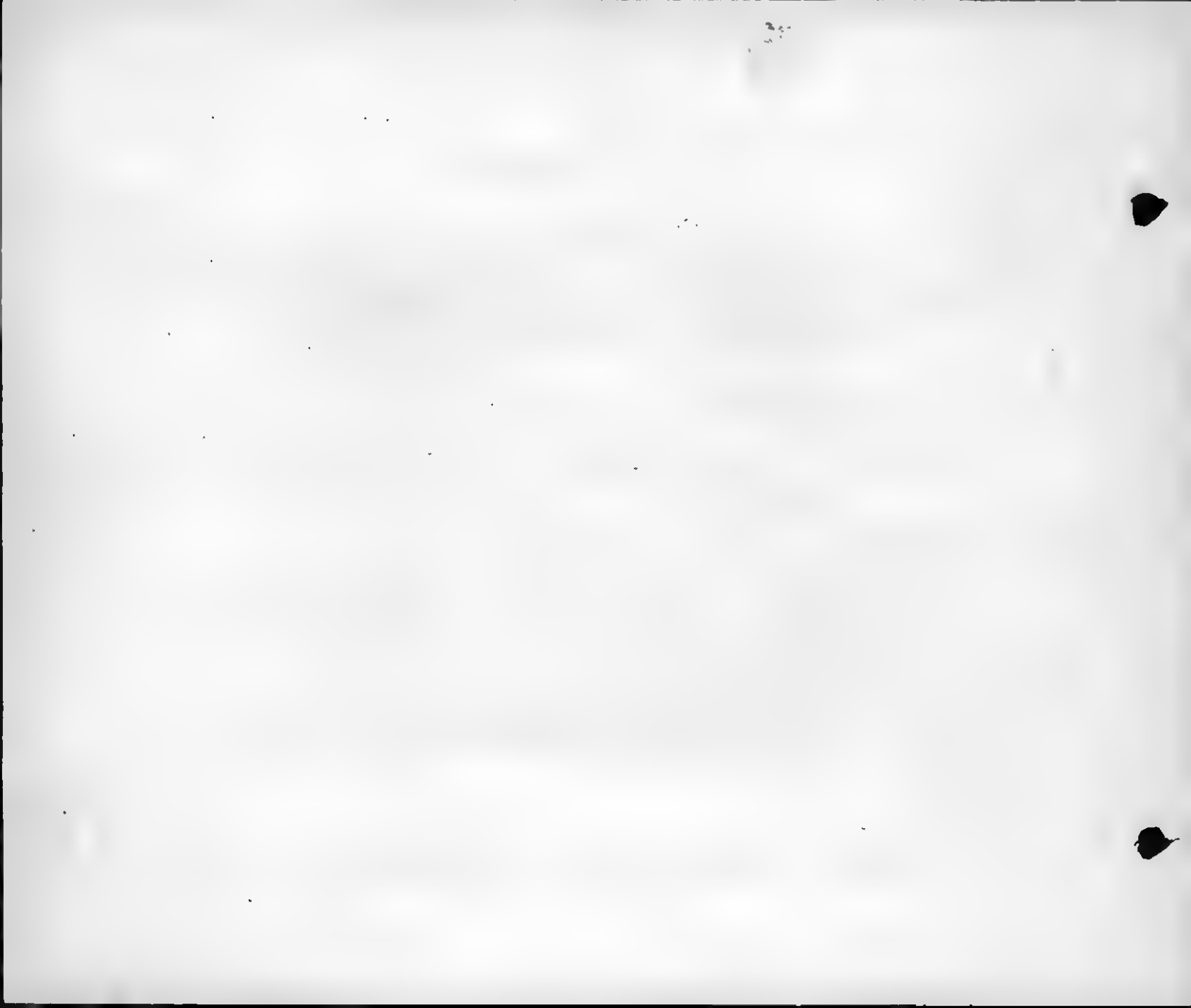
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07452

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institut on /Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>X Jesterville</u>			
3. NAME OF DECEASED (Type or print) <u>George L. Horsman</u>				4. DATE OF DEATH <u>June 14 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/13/1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Builder</u>			
13. FATHER'S NAME <u>Jack Horsman</u>				14. MOTHER'S MAIDEN NAME <u>Julia Ann Covington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-32-6880</u>			
17. INFORMANT <u>Mrs Luke Horsman</u>				Address <u>Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4 weeks</u> <u>10 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>24 April 1960</u> to <u>14 June 1960</u> that (I) (we) last saw the deceased alive on <u>14 June 1960</u> , and that death occurred on <u>14 June 1960</u> at <u>4 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Richard H. Saunders</u>				22b. DATE <u>6/14/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				22d. ADDRESS <u>Nanticoke Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/16/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Jesterville Cem</u>				23d. LOCATION (City, town, or county) (State) <u>Jesterville, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Messick, Biville, Md.</u>				25a. REC'D BY REG STRAR <u>Arthur L. Kraus</u>			
25b. REGISTRAR'S SIGNATURE				DATE <u>JUN 16 '60</u>			

(M)

(I)





FOR STATE  
HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any body is buried, cremated, or otherwise disposed of, the body should be placed in the "pending" position in the medical examiner's office along with form PM-3. Page 5 may be retained for your files. Please forward the certificate, writing the word "pending" in pencil in item 18, to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

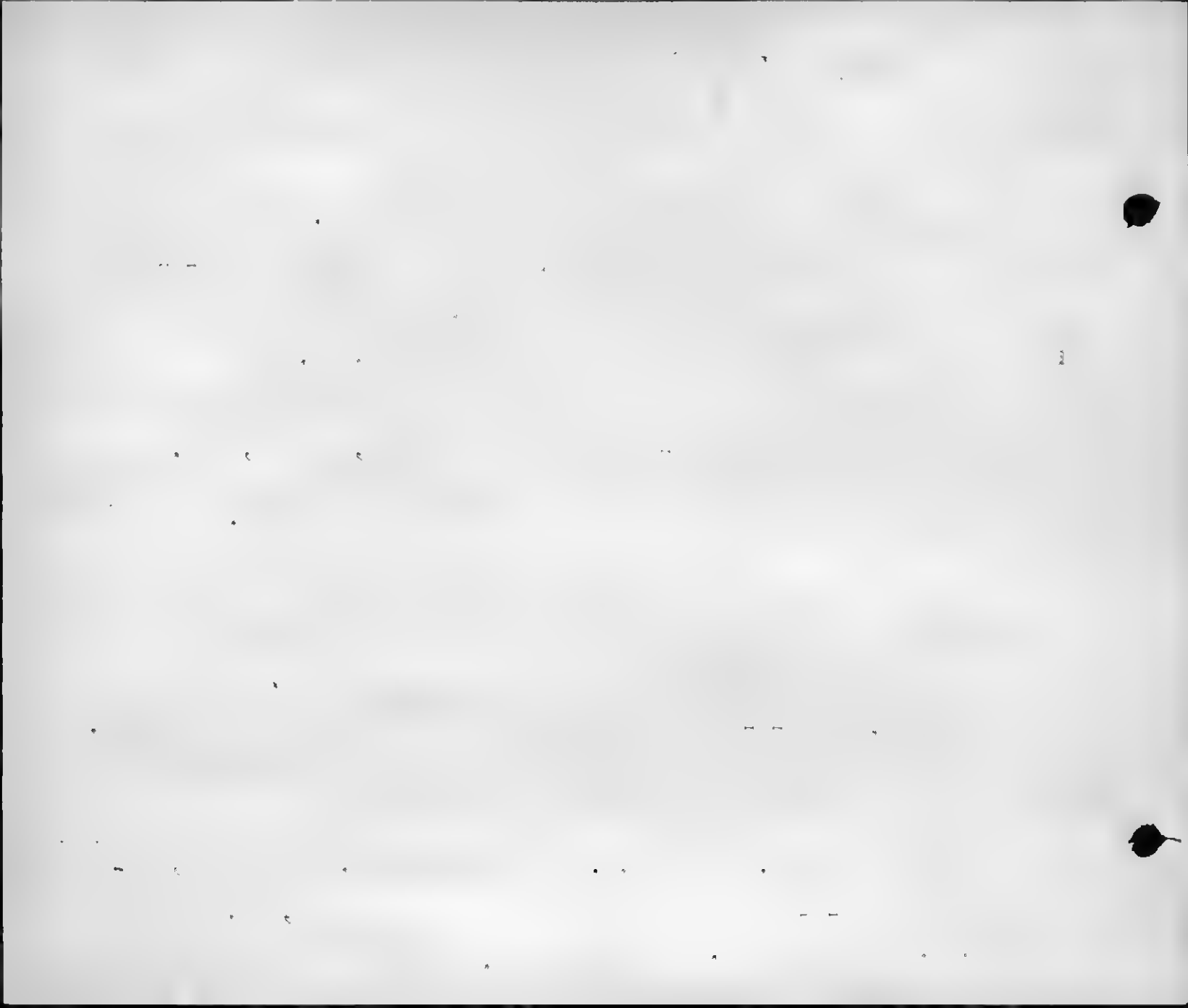
7464

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07453

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>Railroad Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Paul Smith Jones</u>				4. DATE OF DEATH <u>6-5-60</u> 19 <u>19</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept 25, 1907</u> 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Jacob A Jones</u>				14. MOTHER'S MAIDEN NAME <u>Myra H Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> <u>X</u>				16. SOCIAL SECURITY NO. <u>218-05-8118</u>			
17. INFORMANT <u>Dorothy Budd, Delmar, Del.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Second and third degree burns-50% body surface.</u> DUE TO (b) <u>916.0</u> DUE TO (c) <u>916.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell asleep in chair while smoking.</u>					
20c. TIME OF INJURY Month, Day, Year <u>4:30 a.m.</u> <u>6-1-60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Delmar</u> (County) <u>Sussex</u> (State) <u>Del.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6-8-60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Allen</u>				22d. LOCATION (City, town, or country) <u>Allen, Md.</u> (State)			
23. FUNERAL DIRECTOR <u>W. S. Marvel and Co.</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 9 '60</u>			
ADDRESS <u>Delmar, Del.</u>				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>			

MEDICAL CERTIFICATION



7465

## CERTIFICATE OF DEATH

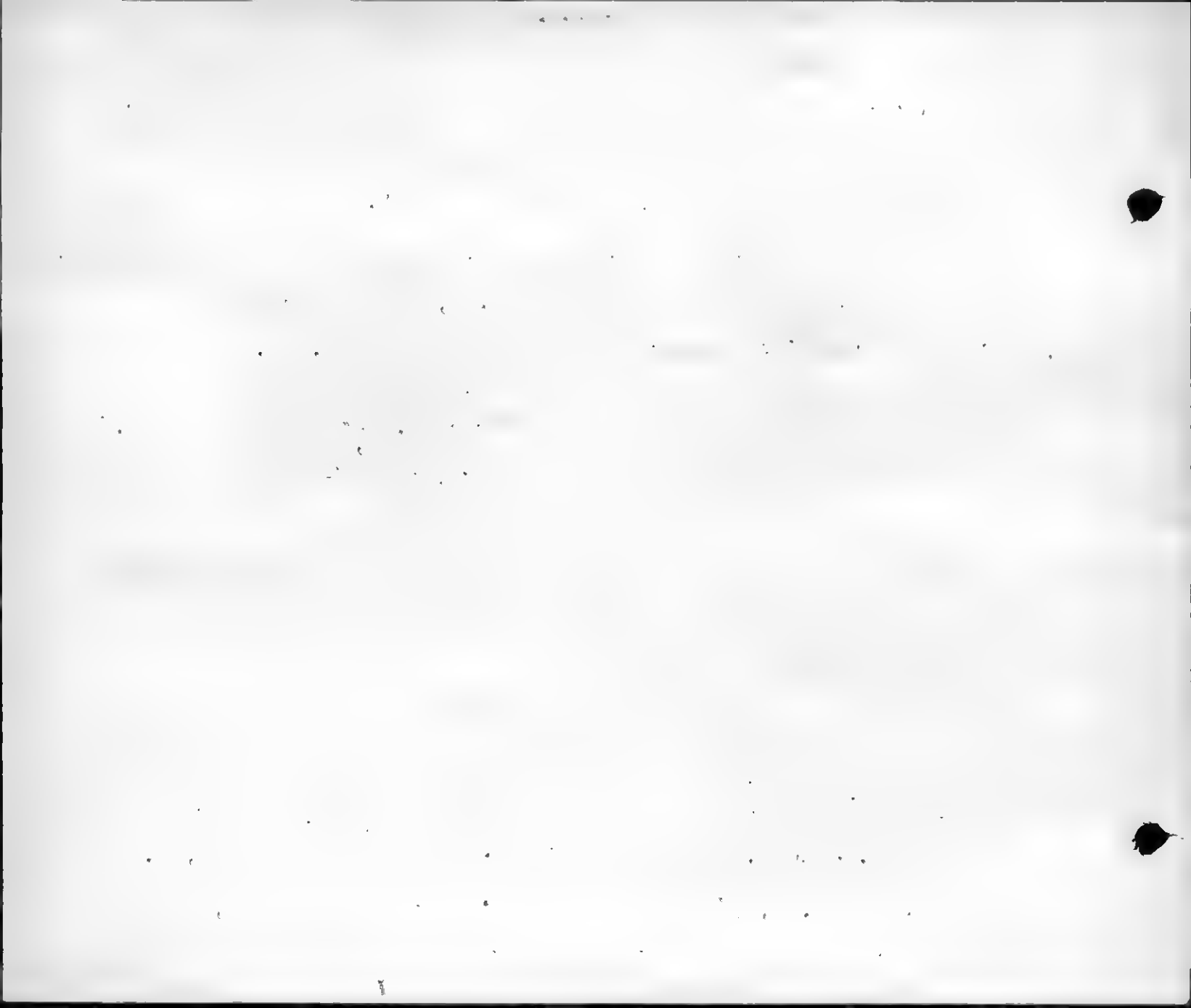
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>12</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Perinatal General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>412 E. Vine St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VIRGIE</u> Middle <u>ANNA</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 26, 1907</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee-Shirt Factory-Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Worcester Co. Md.</u>	11. BIRTHPLACE (State or foreign country) <u>U S A</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Charlie Davis</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Smullen</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		17. ADDRESS <u>Mr. Marion B. Jones (Husband) 412 E. Vine St Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus (diabetic coma)</u> <u>260x</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that I last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>June 9, 1960</u>			
ACTUAL SIGNATURE <u>David J. Gilmore</u>		MEDICAL SIGNATURE <u>Arthur S. Hanna</u>	
PHYSICIAN'S NAME (Type) <u>Dr. David J. Gilmore</u>		Medical Center Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jun. 12, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>JUN 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07455  
Reg. Dist. No.

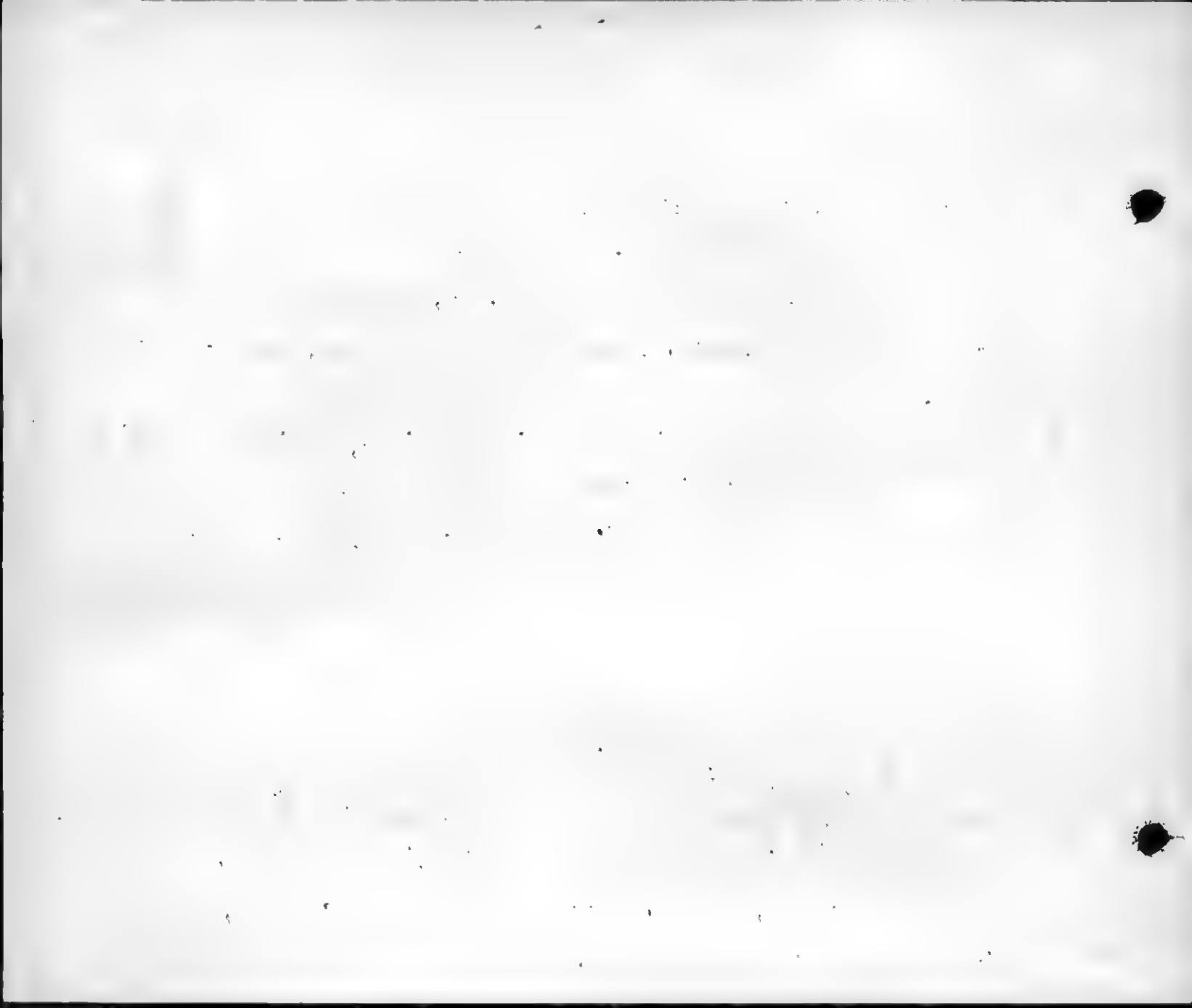
7466

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANKLIN</u> Middle <u>E.</u> Last <u>JOSEPH</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30, 1895</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR <u>7</u> Months <u>17</u> Days	11. IF UNDER 24 HRS <u>17</u> Hours <u>17</u> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employed at Parsons Cemetery-Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Georgetown, Delaware</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Theo. Wm Joseph</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214 10 9960</u>	
17. CAUSE OF DEATH [Enter only one cause per the for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerosis, generalized</u> DUE TO (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <u>6:17</u> <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6:17</u> <u>1960</u> to <u>6:17</u> <u>1960</u> that I last saw the deceased alive on <u>6:17</u> <u>1960</u> , and that death occurred at <u>9:10</u> <u>A.M.</u> from the causes and on the date stated above.		DATE SIGNED <u>6:20.60</u>	
ACTUAL SIGNATURE <u>H. H. Briele</u>		ADDRESS (Street, city or town, state) <u>Medical Center Salisbury Md</u>	
PHYSICIAN'S NAME (Type) <u>H. H. Briele</u>		M.D. <u>Salisbury Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 20, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>JUN 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/7



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7495 CERTIFICATE OF DEATH

07456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>		c. LENGTH OF STAY IN 1b <u>5 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Wardela</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4th &amp; Nanticoke Sts.</u>		d. STREET ADDRESS <u>1 RFD # 1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor Catherine Knowles</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1950</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9, 1910</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garment Operater</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>David Knowles</u>	
14. MOTHER'S MAIDEN NAME <u>Laura Hastings</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>James E. Knowles Sharptown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of fundus of uterus</u> <u>172X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/1</u> , 19 <u>53</u> , to <u>4/4</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>6/14</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Charles M. Moyer</u> M.D. <u>Laurel R. D.</u> PHYSICIAN'S NAME (Type) <u>Charles M. Moyer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/7/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wiverton Church</u>	22d. LOCATION (City, town, or county) (State) <u>Wiverton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>SMITH FUNERAL HOME</u> ADDRESS <u>SHARPTOWN, MD</u>		24a. REC'D BY REGISTRAR <u>JUN 9 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>





## CERTIFICATE OF DEATH

Reg. Dist. No.

07457

7467

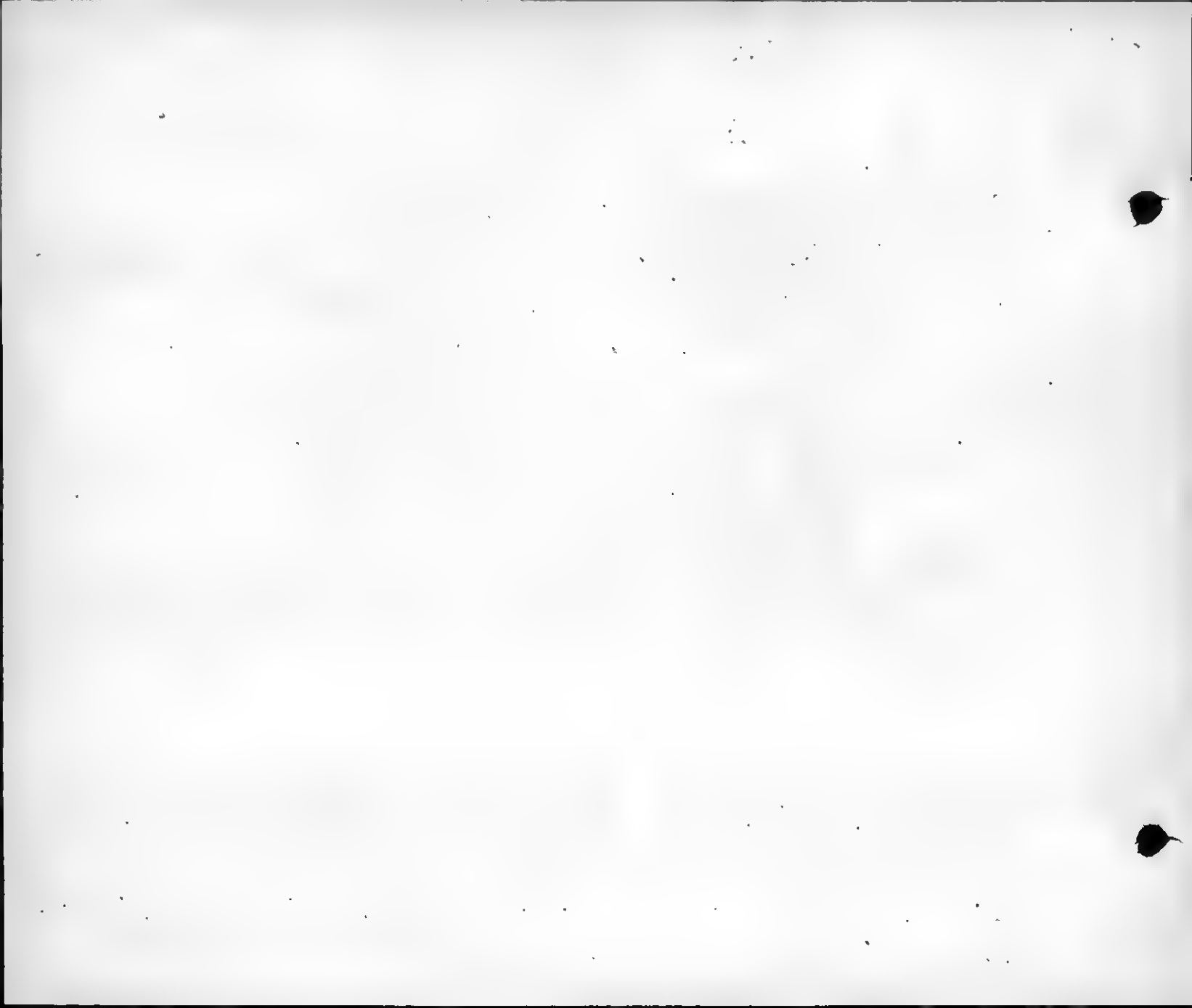
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - POCOMOKE CITY</u>	
c. LENGTH OF STAY IN lb <u>18 HOURS</u>		d. STREET ADDRESS <u>RFD 1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>ELWOOD</u> Middle <u>Lee</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 25 1910</u>
9. AGE (In years last birthday) <u>49</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES E. LEE</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE KING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u> INFORMANT <u>MRS NELLIE LEE, POCOMOKE CITY, MD.</u> Address <u>RFD 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>General Pericarditis</u> <u>25</u> X DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>Centennium</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-18</u> , 19 <u>60</u> , to <u>6-19</u> , 19 <u>60</u> that I last saw the deceased alive on <u>6-19</u> , 19 <u>60</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Wilbur R. Ellis, M.D.</u>		DATE SIGNED <u>6-19-60</u>	
PHYSICIAN'S NAME (Type) <u>WILBUR R. ELLIS, M.D.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-26-60</u>	
22c. NAME OF CEMETERY OR <u>CHRIST METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL - POCOMOKE CITY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Watson</u>		24a. RECEIVED BY REGISTRAR <u>JUN 22 60</u> DATE	
ADDRESS <u>POCOMOKE CITY, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Flinn</u>	

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7468

## CERTIFICATE OF DEATH

Reg. Dist. No. 07458

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 15 <u>1 day</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital / P.F.D.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POWELLVILLE</u> d. STREET ADDRESS <u>P.F.D.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOACE Roscoe Lewis</u>		4. DATE OF DEATH Month Day Year <u>June 22 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 9, 1900</u> 9. AGE (In years last birthday) <u>59</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER TRUCKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMP.</u>	11. BIRTHPLACE (State or foreign country) <u>POWELLVILLE MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>JAMES LEWIS</u>	
14. MOTHER'S MAIDEN NAME <u>ELLA LEWIS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>MR. CLYDE HAMMOND, POWELLVILLE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>Acute and Chronic Pyelonephritis</u> IMMEDIATE CAUSE (a) <u>With Renal Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>With Renal Failure</u> DUE TO (c) <u>With Renal Failure</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Hepatic Cirrhosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>June 21, 1960</u> to <u>June 22, 1960</u> that I last saw the deceased alive on <u>June 21, 1960</u> and that death occurred at <u>6:35 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr. M.D.</u>		ADDRESS (Street, city or town, state) <u>Paris Bluff Rd. Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>		DATE SIGNED <u>6/22/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/25/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. PLEASANT</u>	22d. LOCATION (City, town, or county) (State) <u>POWELLVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burboye</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 24 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krand</u>			

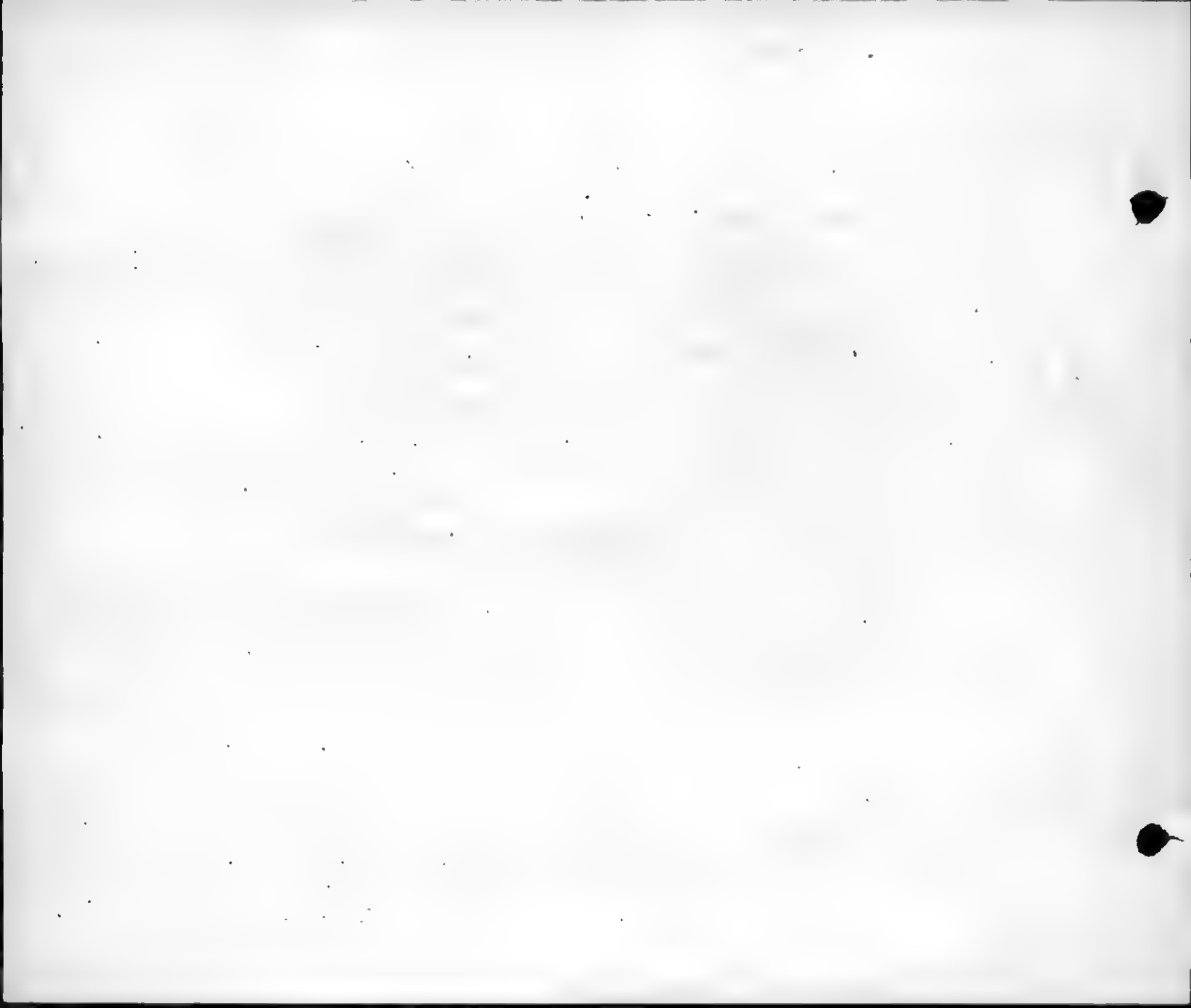
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



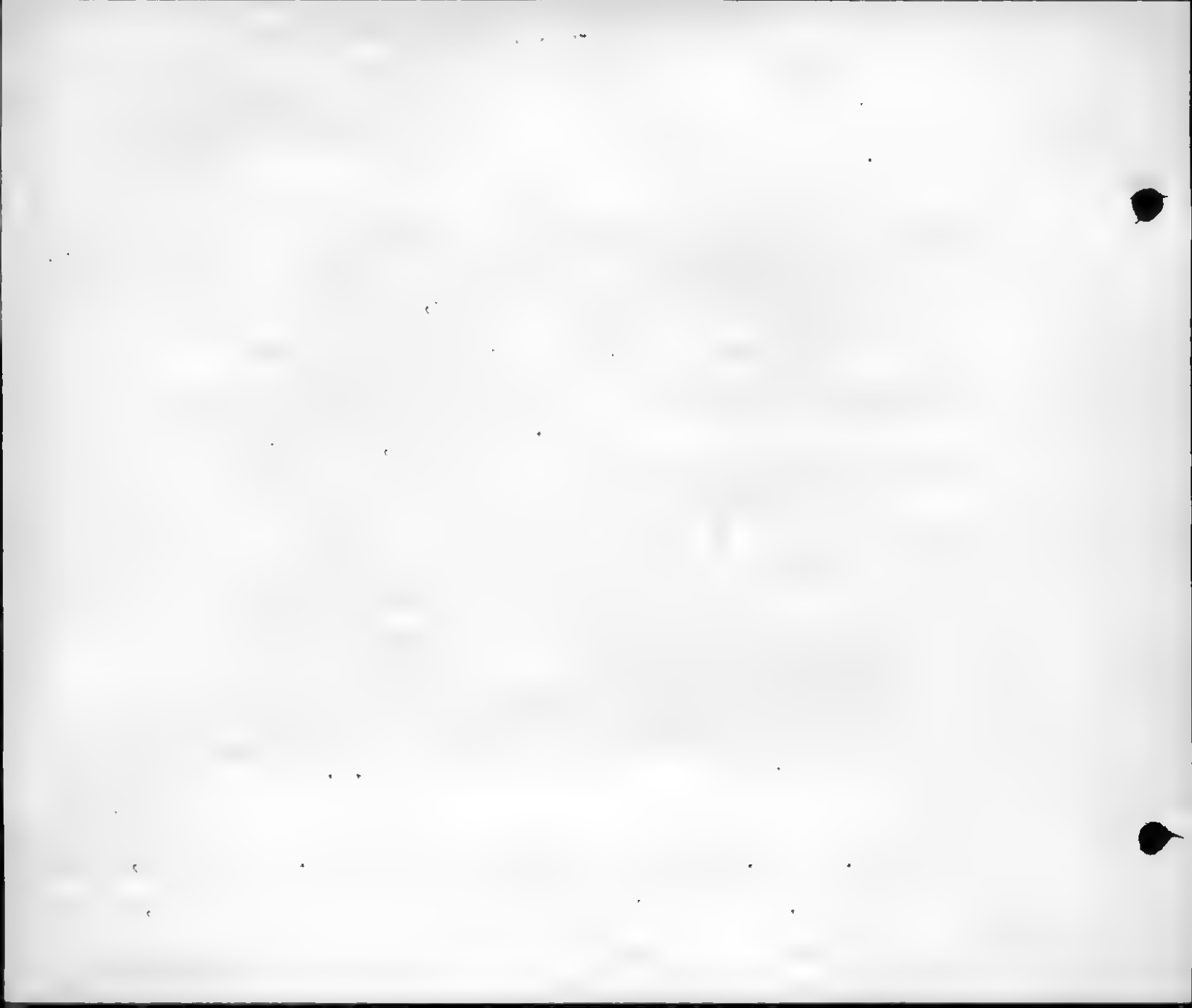
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7469

07459

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Lakewood Drive</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
f. STREET ADDRESS <b>Lakewood Drive</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>FRANCES</b> Last <b>LOMBARDO</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>7th</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 18, 1908</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		12. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
11. BIRTHPLACE (State or foreign country) <b>Rochester New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Joseph Palermo</b>				14. MOTHER'S MAIDEN NAME <b>Mara Adoria Raimondo</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO (If yes, give war or dates of service)			
17. INFORMANT <b>Mr. John Lombardo (Husband)</b>				Address <b>Lakewood Drive Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> 170X DUE TO <b>Carcinoma of Rt. Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>6 yrs</b> DUE TO (c) <b>2 yrs</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>6 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-26-55</b> to <b>6-7-60</b> , that (I) (we) last saw the deceased alive on <b>6-7</b> 19 <b>60</b> , and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Earl L. Royer</b>				22b. DATE <b>June 8th/1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Royer</b>				22d. ADDRESS <b>407 Camden Ave. Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Burial Jun. 10/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Memory Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				25a. REC'D BY REGISTRAR <b>SALISBURY MARYLAND</b>			
25b. REGISTRAR'S SIGNATURE <b>June 10 '60</b>				25c. REGISTRAR'S SIGNATURE <b>Arthur J. Hume</b>			



## CERTIFICATE OF DEATH

07461

Reg. Dist. No.

7470

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
c. LENGTH OF STAY IN 1b <u>12 HOURS</u>		d. STREET ADDRESS <u>Route #2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pocomoke General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRANVILLE N. Merrill</u>		4. DATE OF DEATH Month Day Year <u>June 11 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 24 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MAJOR R. MERRILL</u>		14. MOTHER'S MAIDEN NAME <u>MARY C. MERRILL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-36-1023</u>	
17. INFORMANT <u>M. BURRIS MERRILL</u>		Address <u>Pocomoke City, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1511X</u> DUE TO <u>Branchopneumonia + dehydration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of rectum</u> DUE TO (c) <u>3 months</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Fisher Jr.</u> M.D.		DATE SIGNED <u>Salisbury, MD. 6-11-60</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM H. FISHER JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>6-13-60</u>	<u>PRESBYTERIAN</u>	<u>Pocomoke City, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry B. Watson</u>		24a. REC'D BY REGISTRAR <u>JUN 15 60</u> DATE	
ADDRESS <u>Pocomoke City, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. M...</u>	

1

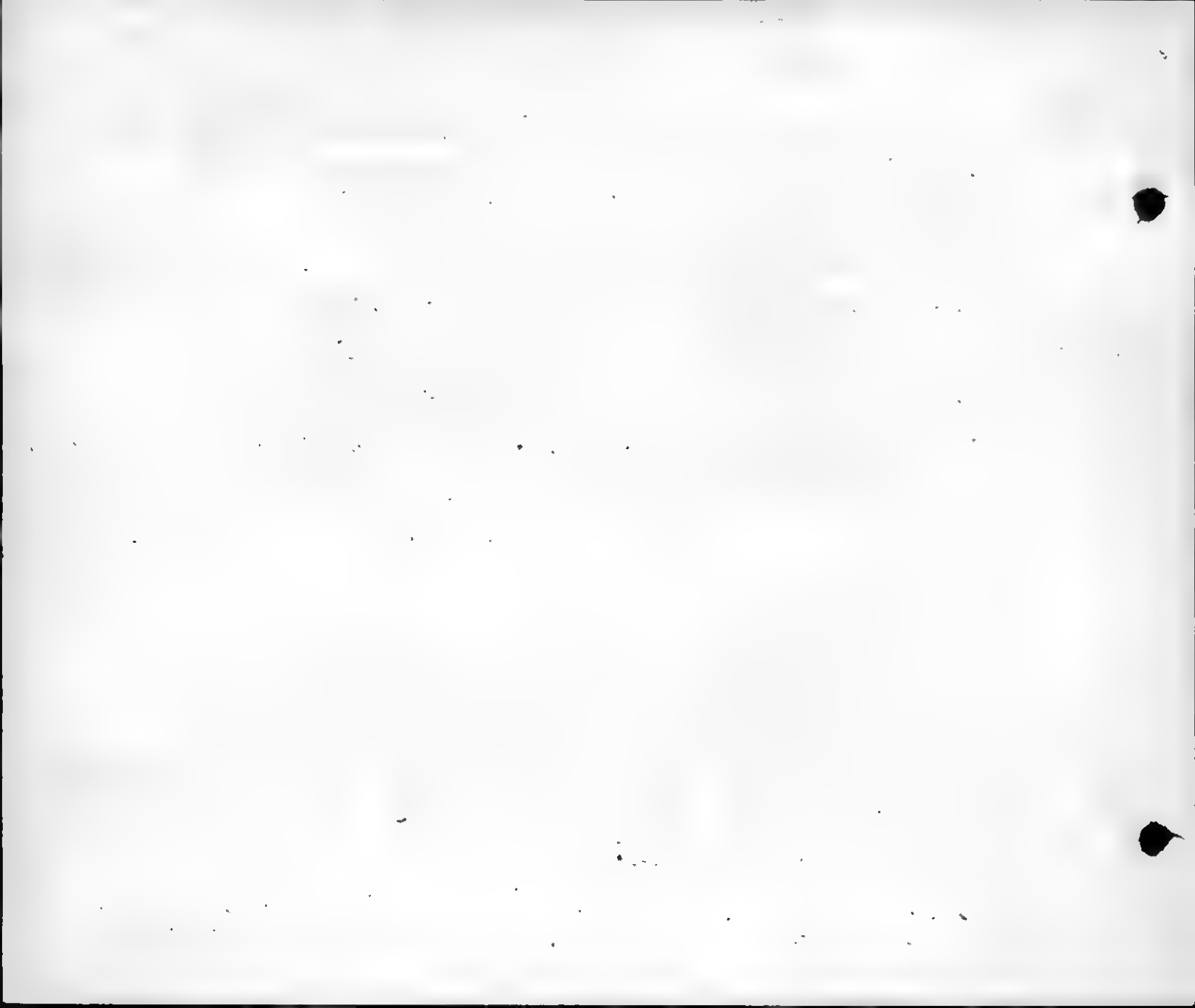
4

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 days after death. The law requires that the death certificate be executed within 14 days after death. The law requires that the death certificate be executed within 14 days after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 8, 9 & 14 Film G267 7/15/60 1wk

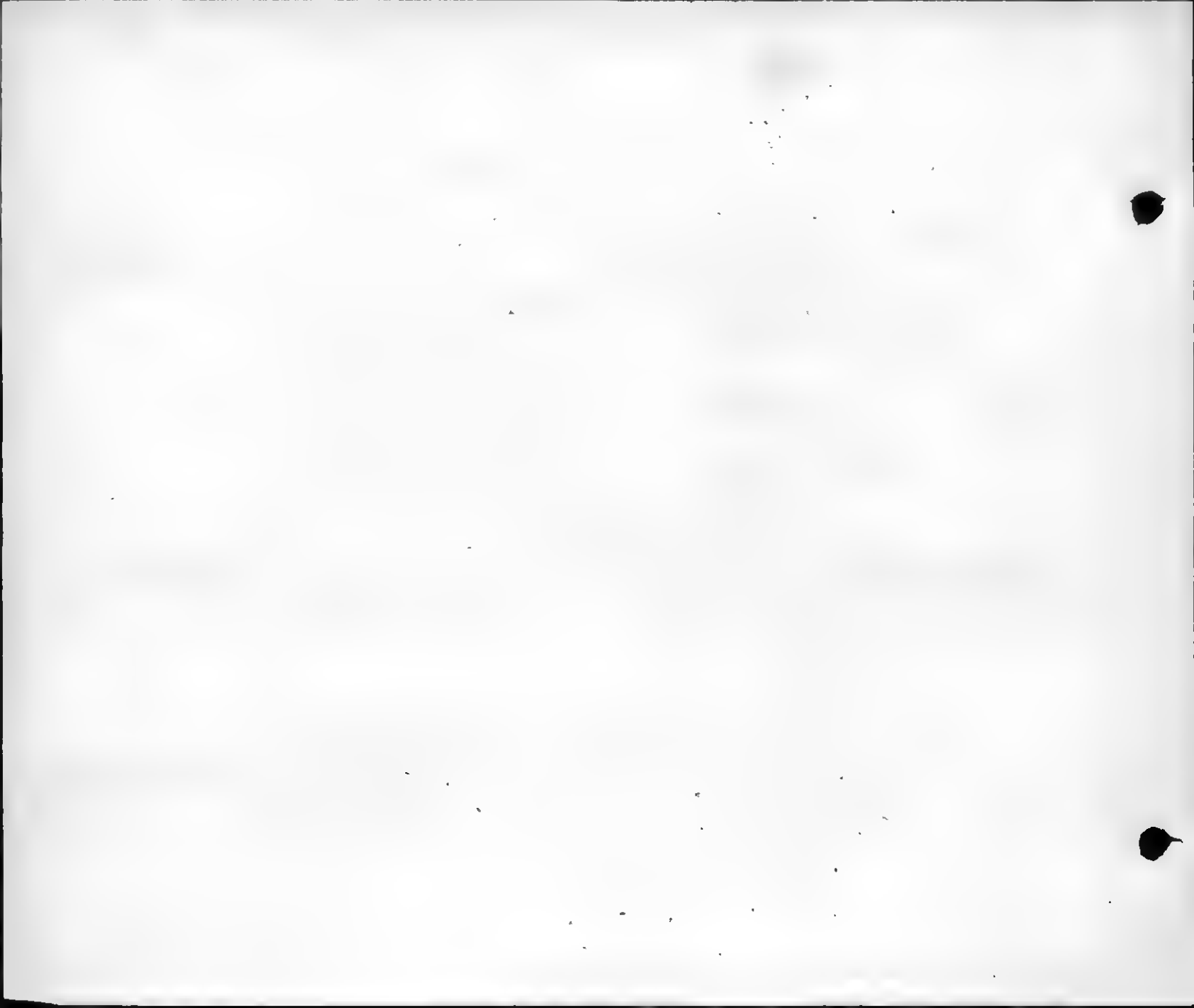
07462

7496

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. 2 Jersey Road Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jersey Road R.F.D. 2</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>B.</u> Last <u>Mitchell</u>				4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 2, 1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Luvenia Weatherly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>Sillian Mitchell R.F.D. 2 Jersey Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Regenerative Heart Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>Indefinite</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>28 May 60</u> to <u>28 June 60</u> last saw the deceased alive on <u>28 June</u> , 19 <u>60</u> and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. A. Purnell</u>				DATE SIGNED <u>5 July 60</u>			
PHYSICIAN'S NAME (Type) <u>E. A. Purnell, M.D.</u>				ADDRESS (Street, city or town, state) <u>652 W. MAIN ST Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Clinton F. Stewart</u>	



7471

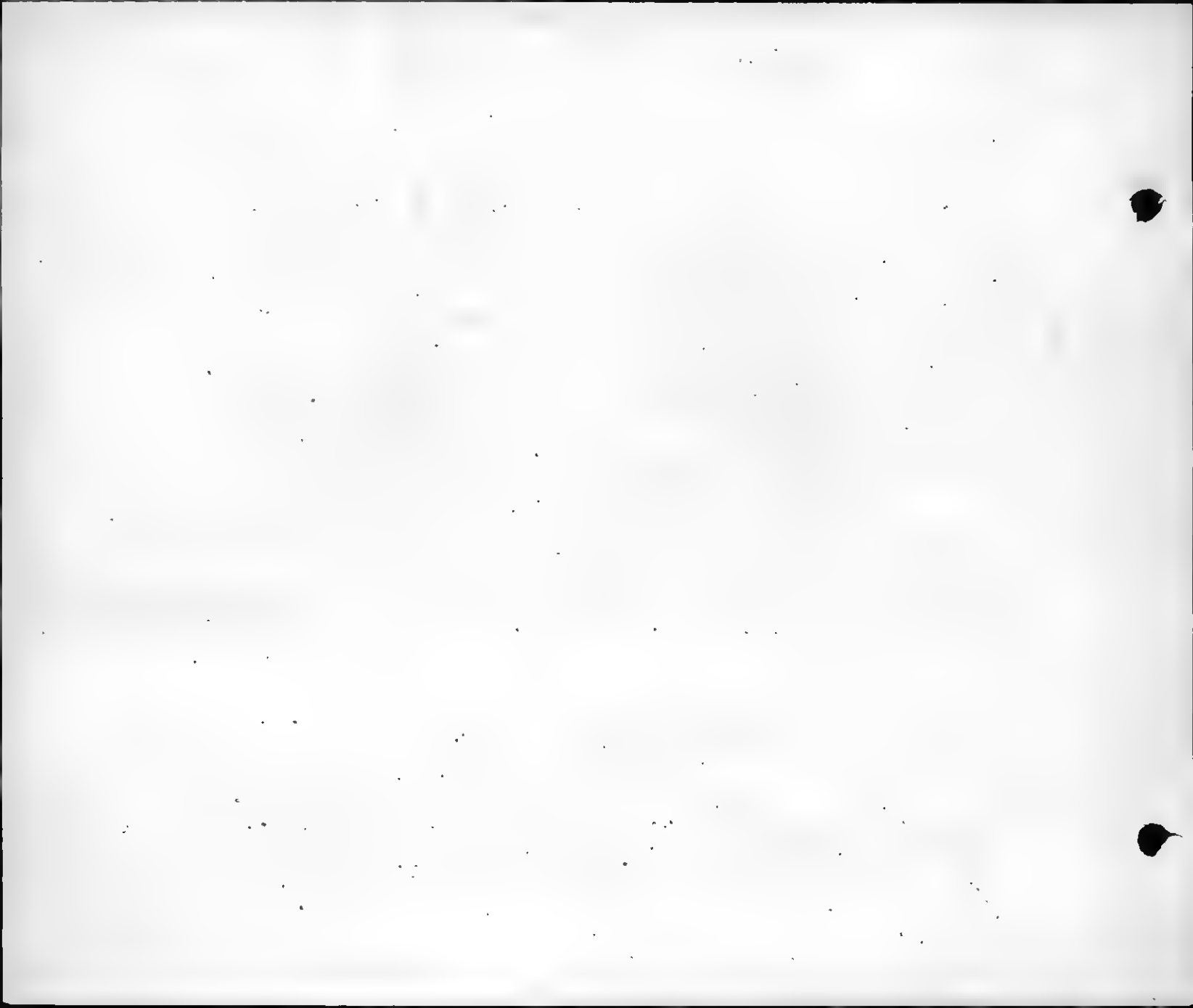
## CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>35 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEWESULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wic</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury md</u> d. STREET ADDRESS <u>Take SH Route 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORIDA ANNA NICHOLS</u>		4. DATE OF DEATH Month Day Year <u>June 27 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1904</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>va</u>	
13. FATHER'S NAME <u>Walter J. Holden</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Holden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Bertina Nichols</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ca of Lungs</u> 113X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Same</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 mos.</u> <u>15 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Heart Disease; Bronchial Asthma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Shingles Syndrome</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 15, 1959</u> to <u>June 27, 1960</u> that I last saw the deceased alive on <u>June 27, 1960</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Herbert Sembly</u> M.D.		ADDRESS (Street, city or town, state) <u>400 E. Church St. Salisbury, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly</u>		DATE SIGNED <u>6/27/60</u>	
22a. BURIAL, CREMATION OR OTHER FINAL DISPOSITION <u>Burial</u>	22b. DATE THEREOF <u>7-3-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barbara H. East</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>JUL 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No. 7466

7472

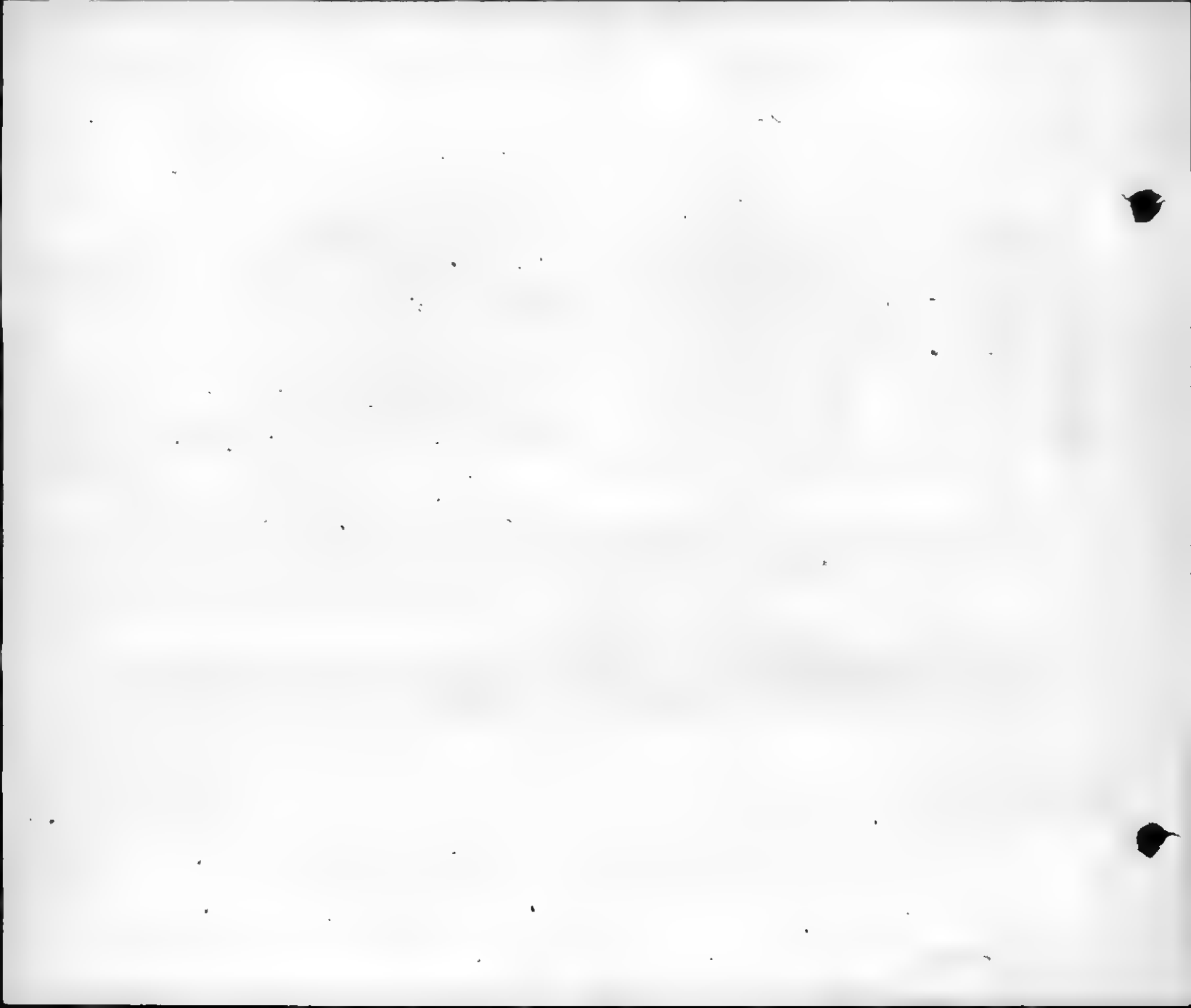
1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived (if institution, residence before admission)) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCESS ANNE GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ray</u> Middle <u>Nichols</u> Last <u>Nichols</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Henry Nichols</u>	
14. MOTHER'S MAIDEN NAME <u>Mateldia Minton</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>  </u>	
16. SOCIAL SECURITY NO. <u>  </u>		INFORMANT <u>Mrs. Maurice Payne R.F.D. Princess Anne</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>
21. I certify that I attended the deceased from <u>June 15, 1960</u> , to <u>June 15, 1960</u> , that I last saw the deceased alive on <u>June 15, 1960</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr., M.D.</u>		ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>  </u>		DATE SIGNED <u>6/15/60</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/17/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Episcopal</u>	22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Hannon</u>		ADDRESS <u>Princess Anne Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur D. Hannon</u>	

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)  
15M 9/58



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and destroy papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

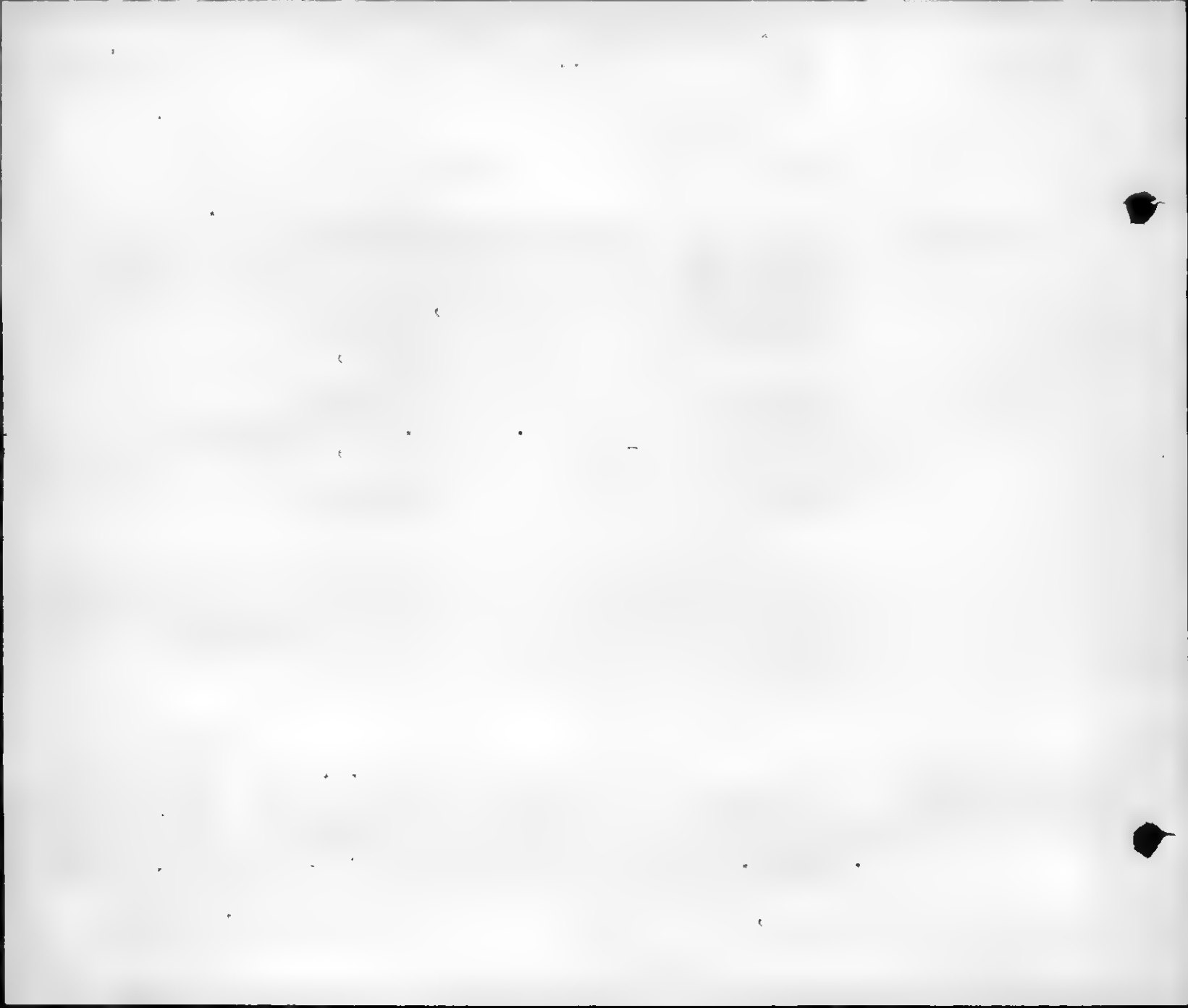
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7473

CERTIFICATE OF DEATH

07465

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>605 Oak Hill Ave</b>		d. STREET ADDRESS <b>605 Oak Hill Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>GRANVILLE</b> Middle <b>BENJAMIN</b> Last <b>PARKER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>29th</b> Year <b>1960</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1881</b>
9 AGE (In years last birthday) <b>79</b> yrs		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Meat Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Butcher</b>	
11. BIRTHPLACE (State or foreign country) <b>Powellville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Robert Parker</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Lewis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>214-10-8729</b>	
17. INFORMANT <b>Mrs. Sarah M. Parker (Wife)</b>		Address <b>605 Oak Hill Ave. Salisbury, Maryland</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>321X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>Arteriosclerotic Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> N/A Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>10/12, 1959</b> to <b>6/29 1960</b> , that (I) (we) last saw the deceased alive on <b>6/29 1960</b> , and that death occurred at <b>9:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>David J. Gilmore</b>		22b. DATE SIGNED <b>July 30 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. David J. Gilmore</b>		22d. ADDRESS <b>Medical Center - Salisbury, Maryland</b>	
23a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial July 2, 1960</b>		23b. DATE THEREOF <b>July 2, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
25a. REC'D BY REGISTRAR <b>JUL 5 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	





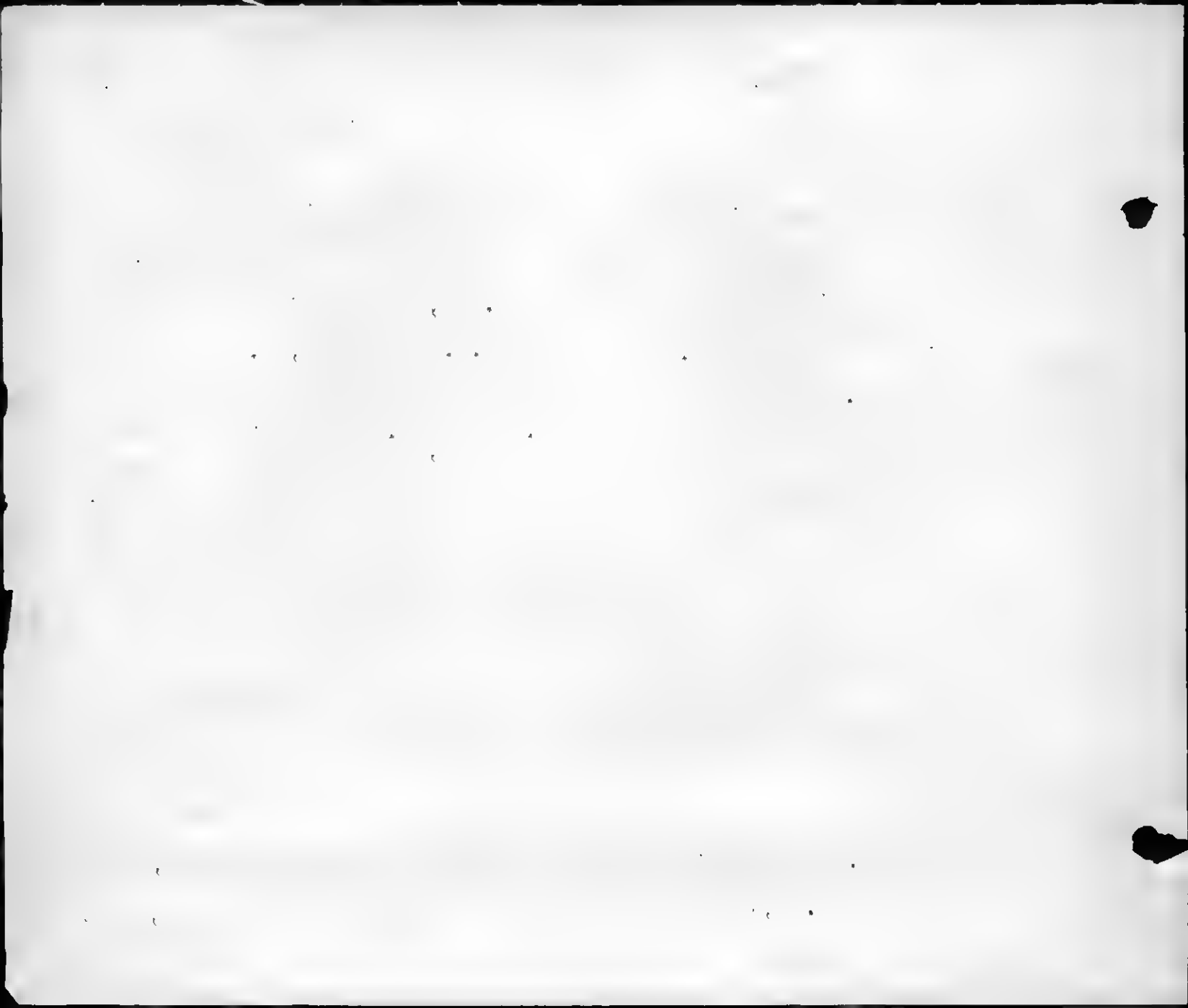
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07466

7474

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		d. STREET ADDRESS <b>Lillian St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EARL WESLEY PHIPPIN</b>		4. DATE OF DEATH <b>June 21st, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1909</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee (Wayne Pump Co.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.D.# Quantico, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Harrison M. Phippin</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Emily Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes II</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT Mrs. Dorothy L. Phippin (Wife) Lillian St Hebron, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 day</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6-20, 1960</b> to <b>6-21, 1960</b> that (I) (we) last saw the deceased alive on <b>6-21, 1960</b> , and that death occurred <b>8:45 P.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Dr. Wilbar R. Ellis Jr.</b>		22b. DATE <b>June 21, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Wilbar R. Ellis Jr.</b>		22d. ADDRESS <b>Medical Center Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Jun. 24, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Memory Gardens</b>	23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>JUN 24 '60</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
#  
M  
1  
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

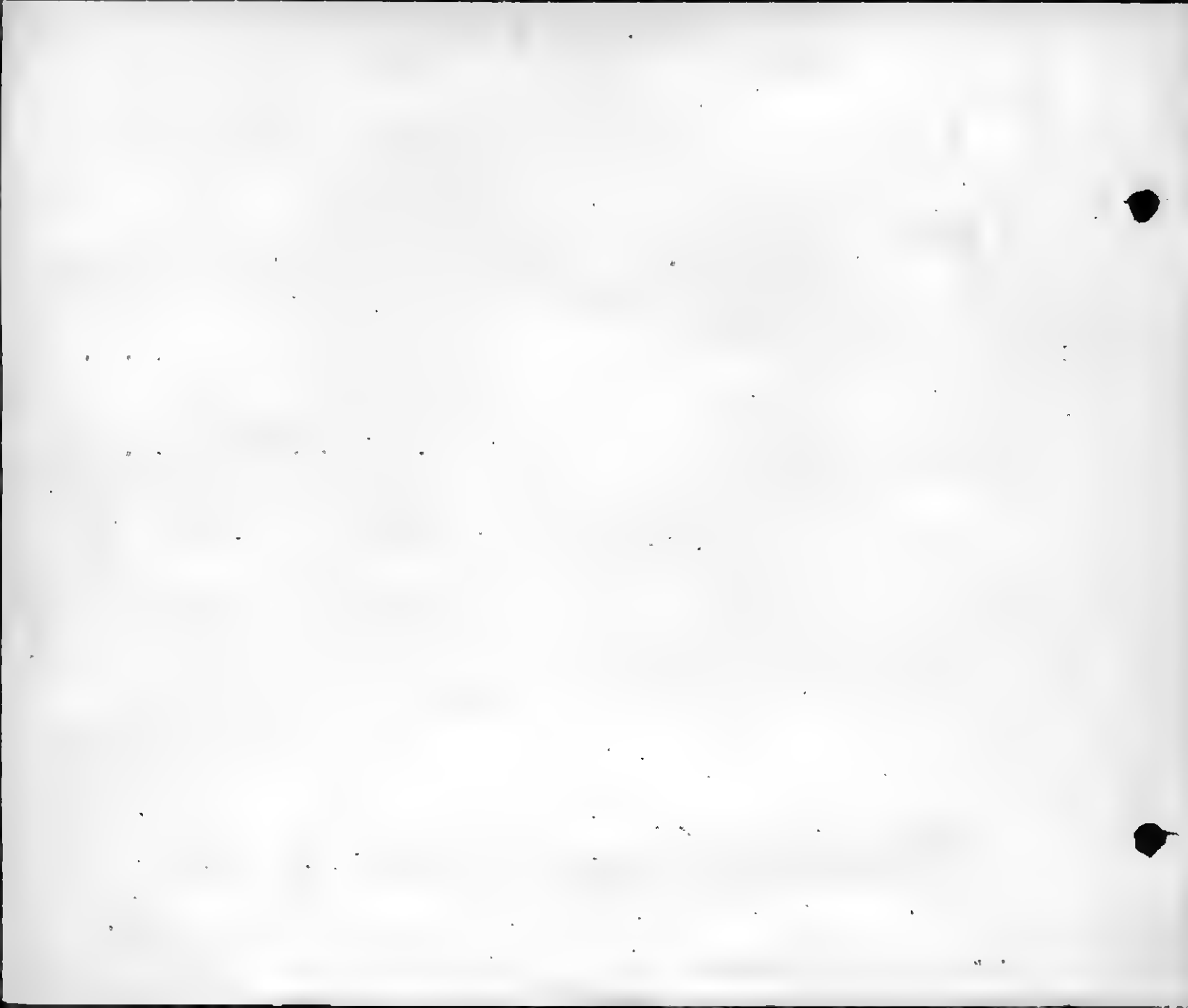
Item 2 Fil 32 56-18- ) et

## CERTIFICATE OF DEATH

Reg. Dist. No.

07467

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL		e. STREET ADDRESS /Salisbury Berlin		f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James E. PIERCE		4. DATE OF DEATH JUNE 5 1960		5. SEX MALE	
6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 22, 1910	
9. AGE (In years last birthday) 50 yrs.		10. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S. A.		13. FATHER'S NAME Wesley Pierce		14. MOTHER'S MAIDEN NAME Ada Fooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [blank]		INFORMANT Address Anna Massadin R.F.D. 3 Berlin Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.6 DUE TO PNEUMONITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 540.6 DUE TO PERFORATED GASTRIC ULCER (c) [blank]					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) [blank]					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) [blank]		20g. (County) [blank]		20h. (State) [blank]	
21. I certify that I attended the deceased from May 16, 1960, to 6/5, 1960, that I last saw the deceased alive on 6/5, 1960, and that death occurred at 2:48 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J. M. Bloxom III M.D. 6/5/1960 PHYSICIAN'S NAME (Type) J. M. BLOXOM III SALISBURY, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/1960		22c. NAME OF CEMETERY OR CREMATORY German Town	
22d. LOCATION (City, town, or county) Berlin		22e. (State) Md.		22f. REC'D BY REGISTRAR DATE JUN 10 '60	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart		23b. ADDRESS Salisbury Md.		23c. REGISTRAR'S SIGNATURE Arthur S. Howard	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7476

## CERTIFICATE OF DEATH

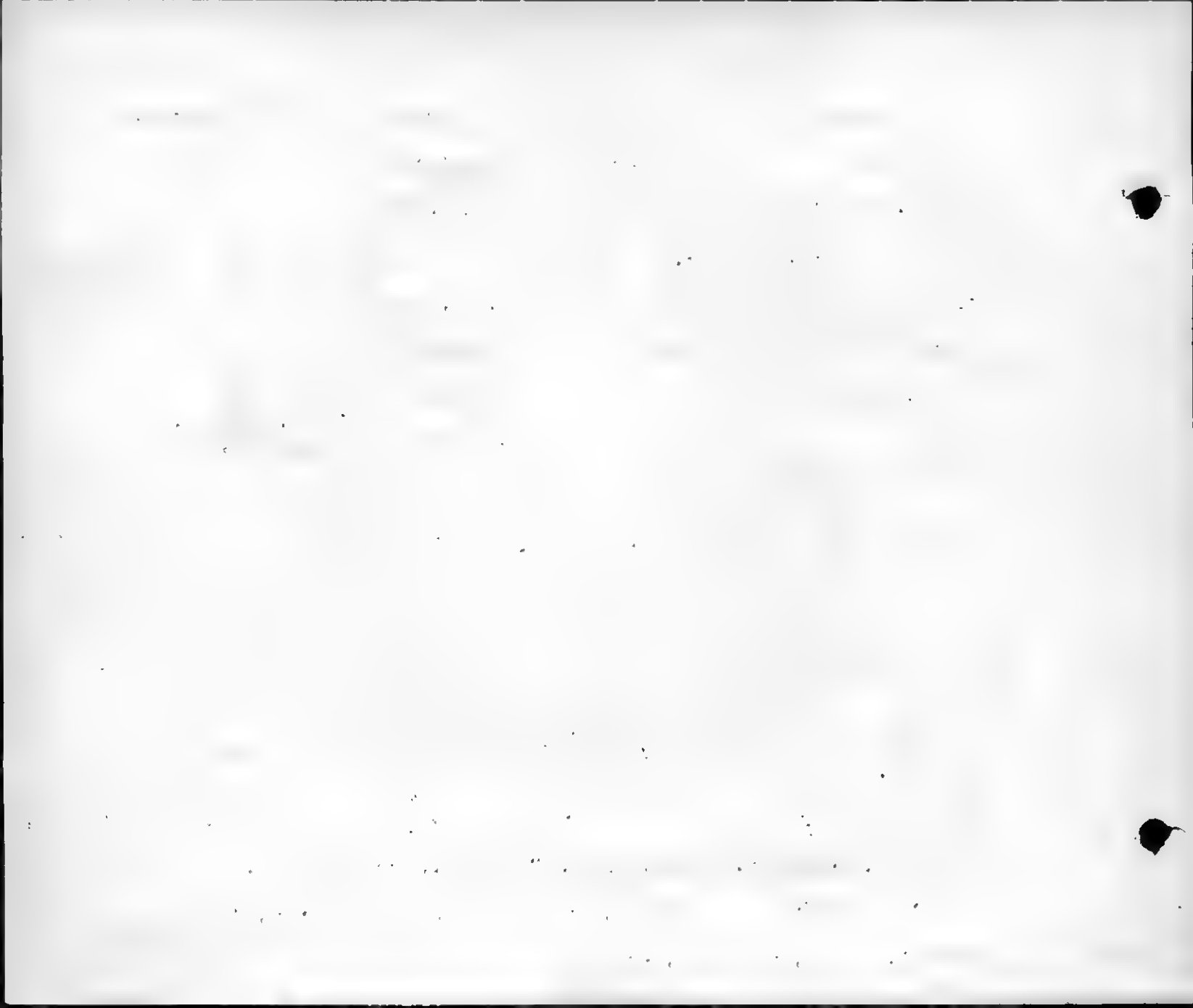
Reg. Dist. 07468

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>all her life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>652 W. Main St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>P.</b> Last <b>Purnell</b>		4. DATE OF DEATH Month <b>E</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1884</b>
9. AGE (In years last birthday) yrs. <b>75</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lt Cottman</b>		14. MOTHER'S MAIDEN NAME <b>Hennie ? Cottman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro sclerosis</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Unknown</b> (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 15, 1960</b> to <b>June 3, 1960</b> , that I last saw the deceased alive on <b>May 31, 1960</b> , and that death occurred at <b>29</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury Md</b> DATE SIGNED <b>June 13, 1960</b>			
ACTUAL SIGNATURE <b>Herbert G. Sembly</b> M.D.		DATE SIGNED <b>June 13, 1960</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Herbert G. Sembly, 400 E. Church St., Salisbury, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/6/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Acre Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thornton B. Jelley, Salisbury, Md</b>		24a. REC'D BY REGISTRAR <b>JUN 16 60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

VS A15 (4)  
ISM 9/58

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

7477  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07469

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 mo. 11 da.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville		17 2	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS Box 292	
e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Cinda Jane Ray		4. DATE OF DEATH Month Day Year June 11 1960	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1917
9 AGE (in years last birthday) 43 -- yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) Hatfield, Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James E. Hunt		14. MOTHER'S MAIDEN NAME Stella Pinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16 SOCIAL SECURITY NO. 406-36-6626	
17 INFORMANT Hospital Records -- Salisbury, Maryland		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 600.0 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of Cervix		INTERVAL BETWEEN ONSET AND DEATH 8 mo. ? 1 yr. ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/2/1960 to 6/11/1960, that (I) (we) last saw the deceased alive on 6/11/1960, and that death occurred at 1:35 PM from the causes and on the date stated above			
22a. SIGNATURE L. Maldve, M.D.		22b. DATE SIGNED June 11, 1960	
22c. PHYSICIAN'S NAME (Type) L. Maldve, M.D.		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-16-60	
23c. NAME OF CEMETERY OR CREMATORY BEVENS CEMETERY		23d. LOCATION (City, town, or county) (State) BELTRY, KENTUCKY	
24. FUNERAL DIRECTOR'S SIGNATURE Robert Waller		25a. REC'D BY REGISTRAR JUN 14 60	
25b. REGISTRAR'S SIGNATURE Charles L. ...		DATE	





TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

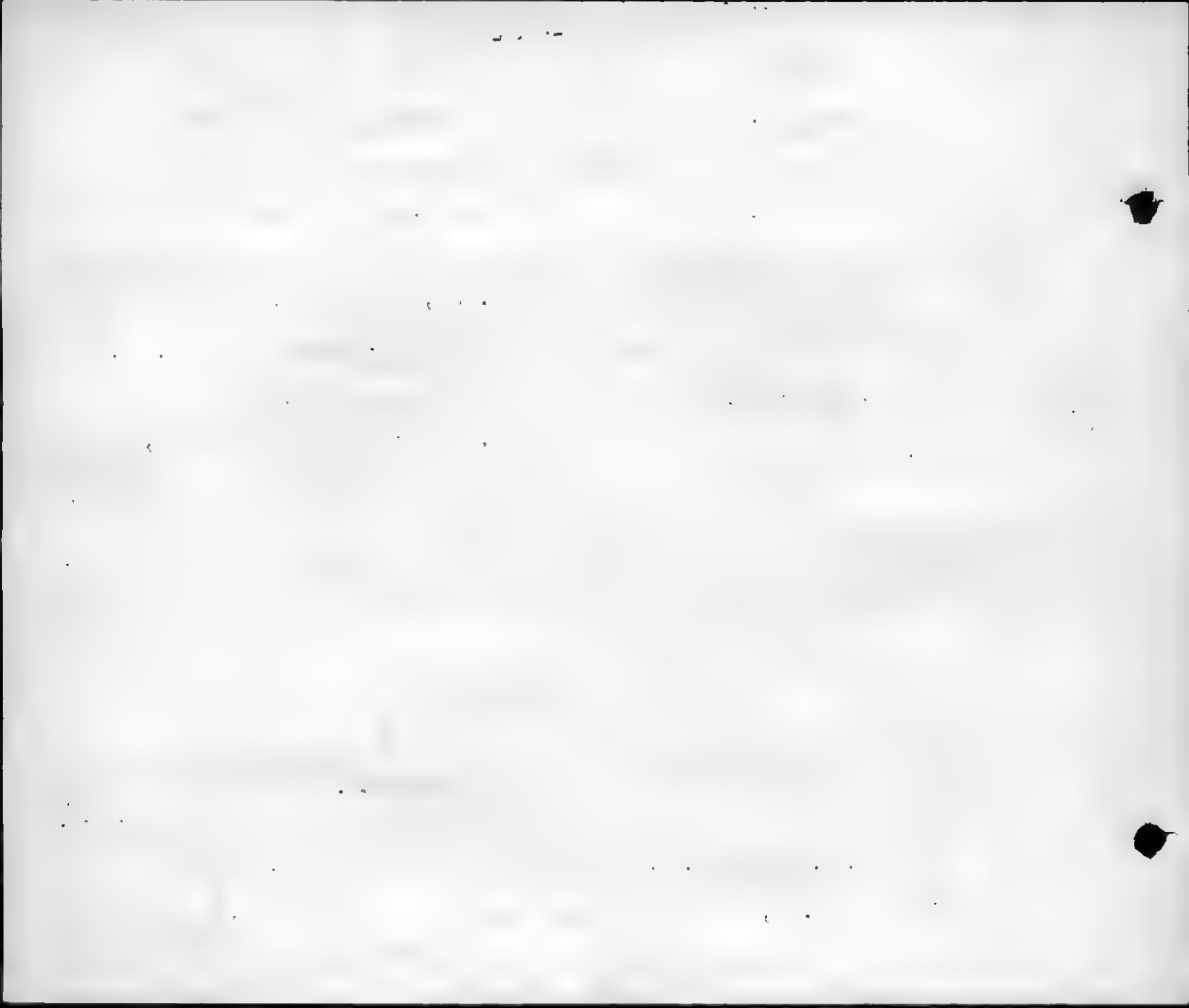
7478

CERTIFICATE OF DEATH

07470

Item 2 filed 6-20-60 at

1. PLACE OF DEATH a. COUNTY <b>WICOMICO CO.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head Hospital</b>		d. STREET ADDRESS <b>Delmar Road</b>	
3. NAME OF DECEASED (Type or print) First <b>LUCIA</b> Middle <b>--</b> Last <b>RICE</b>		4. DATE OF DEATH Month <b>6</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 26, 1872</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Worcester</b>		14. MOTHER'S MAIDEN NAME <b>Frances Bentley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Deer's Head Records</b> Address <b>John B. Parsons Home-Lemon Hill, Salisbury Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (If in hospital) attended the deceased from <b>11/10, 1958</b> to <b>6/15, 1960</b> that (I) (we) last saw the deceased alive on <b>6/15, 1960</b> , and that death occurred at <b>3:50 p.m.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Maldve</b>		22b. DATE SIGNED <b>6-16-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jun. 18, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
25a. REC'D BY REGISTRAR <b>JUN 20 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Froude</b>	



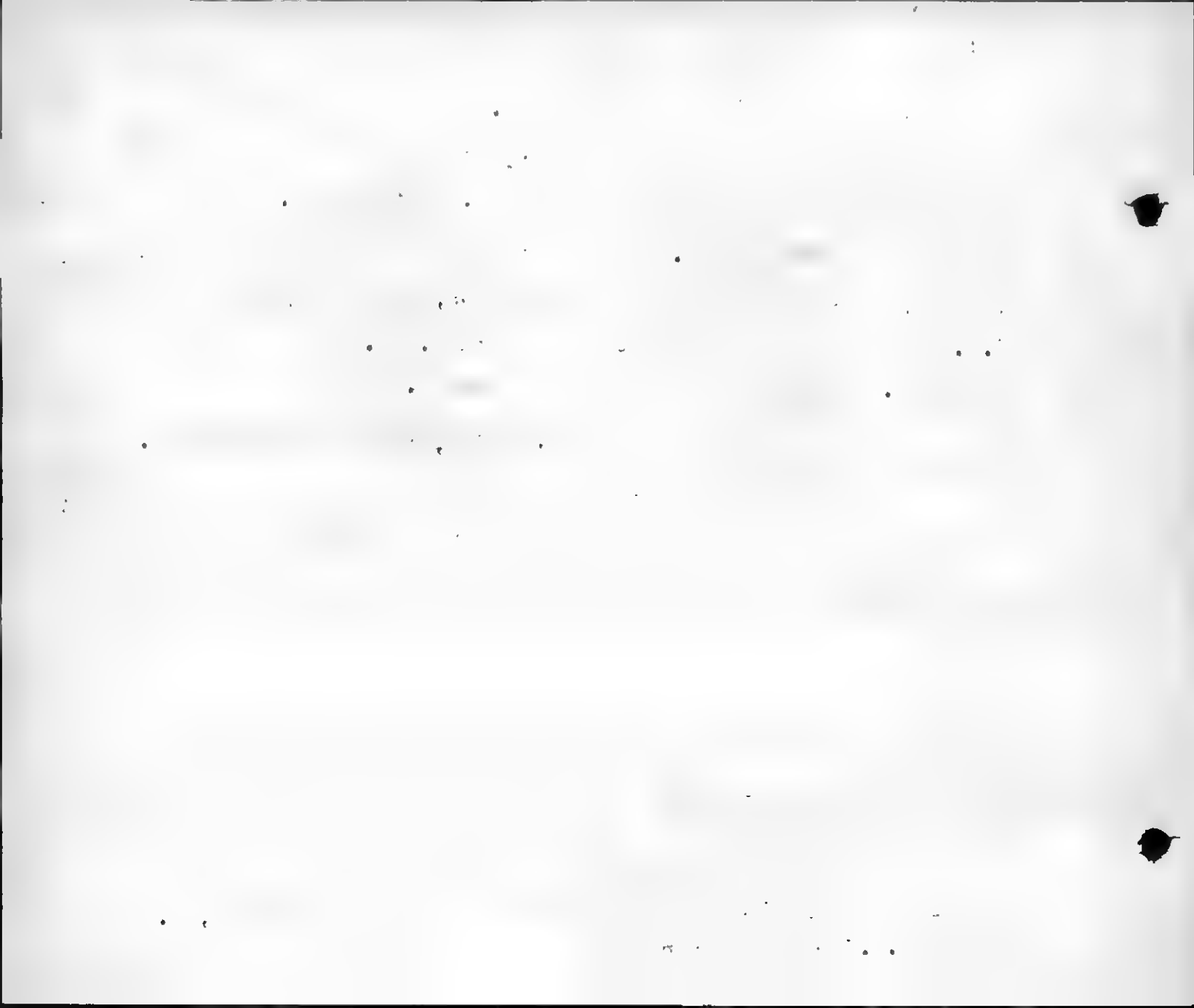
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Tlien please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
7479									
CERTIFICATE OF DEATH									
Reg. Dist. No. 07471									
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b					2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>					d. STREET ADDRESS <u>46 N. Bentalou St.</u>				
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>M.</u> Last <u>RUSSELL</u>					4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1960</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1876</u>		9. AGE (In years lost birthday) <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Joseph H. Maskell</u>					14. MOTHER'S MAIDEN NAME <u>Anna C. Cull</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>					16. SOCIAL SECURITY NO <u>INFORMANT (Nephew)</u> <u>Elmer Bing, 8151 Loch Raven Blvd.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332</u> IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> DUE TO (b) <u>generalized arterio sclerosis</u> DUE TO (c) <u>indigents</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>While at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>									
20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>MAY 6, 1960</u> to <u>JUNE 5, 1960</u> , that I last saw the deceased alive on <u>JUNE 5, 1960</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Robert J. Adkins</u> M.D. <u>Fruitland, Maryland</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>6/5/60</u>									
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
22b. DATE THEREOF <u>June 9/60</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>									
22d. LOCATION (City, town, or county) (State) <u>Baltimore 29, Md.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke F.D. 4101 Edmondson Ave</u> ADDRESS									
24a. REC'D BY REGISTRAR DATE <u>JUN 7 '60</u>									
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>									

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7480

## CERTIFICATE OF DEATH

Reg. Dist. **07472**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>10 HOURS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>EMMA</b> Middle <b>C.</b> Last <b>Scott</b>				<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 8, 1890</b>	
9. AGE (In years last birthday) <b>70</b> yrs		IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min.		IF UNDER 24 HRS		IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				13. FATHER'S NAME <b>JOHN T. COCHRANE</b>			
14. MOTHER'S MAIDEN NAME <b>EVA S. VANPELT</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>219-07-4166</b>				17. INFORMANT <b>EDWARD L. SCOTT, POCOMOKE CITY, MD.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infection and Necrosis of Jejunum</b> DUE TO (b) <b>Mesenteric Thrombosis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>Arteriosclerosis and Hypertension</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 21, 1960</b> , to <b>June 21, 1960</b> , that I last saw the deceased alive on <b>June 21, 1960</b> , and that death occurred at <b>12:50 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas C. Hill, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Pine Bluff Rd, Salisbury, Md</b>			
PHYSICIAN'S NAME (Type) <b>THOMAS C. HILL, JR.</b>				DATE SIGNED <b>6/22/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-24-60</b>		22c. NAME OF CEMETERY <b>UNION GREENBACKVILLE</b>		22d. LOCATION (City, town, or county) (State) <b>WORCESTER COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>				ADDRESS <b>Pocomoke City, MD.</b>			
24a. REC'D BY REGISTRAR <b>JUN 27 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Orlino S. Hanna</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

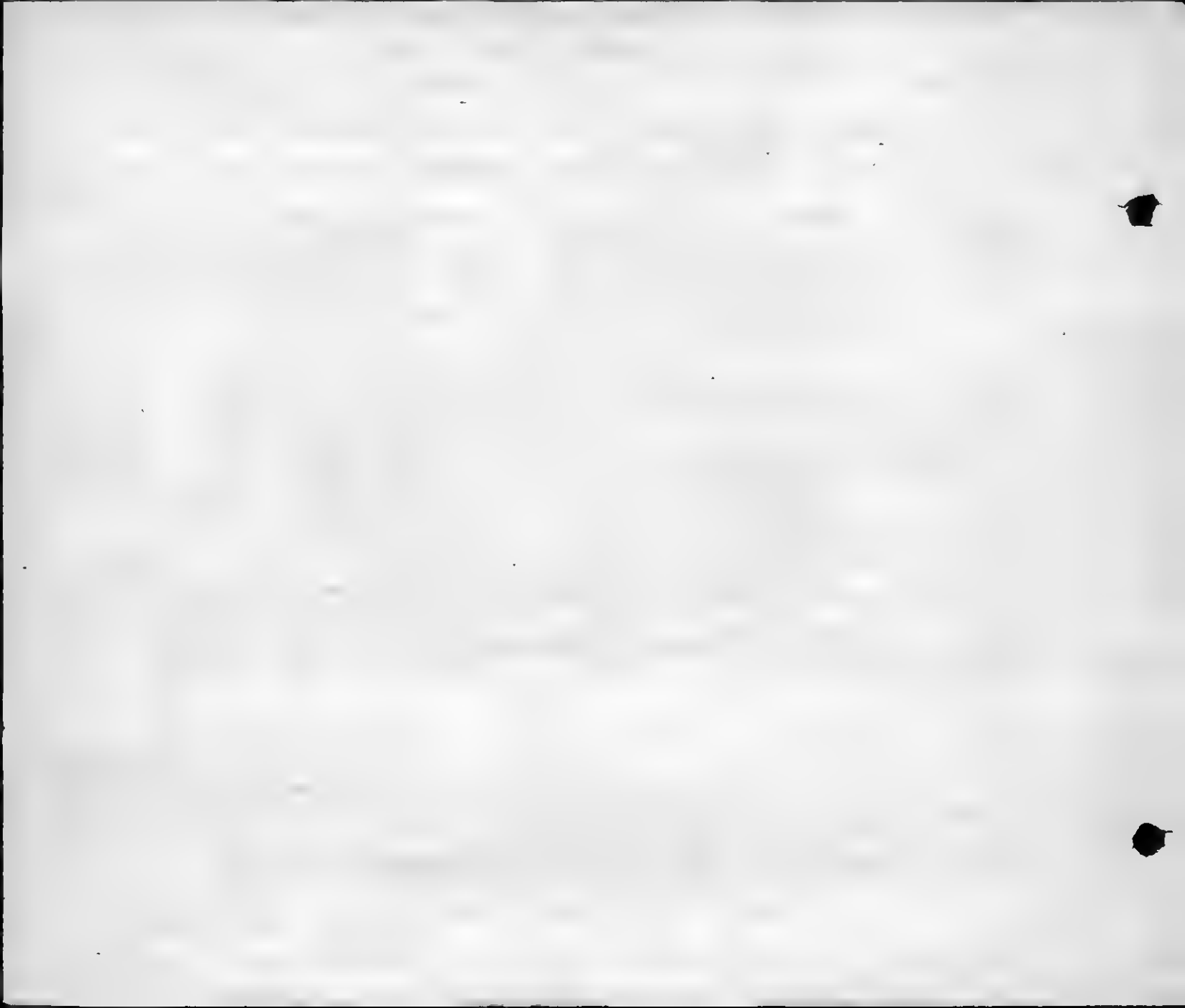
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>VIRGINIA</u> b. COUNTY <u>ACCOMAC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - HORSEY, VA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOME</u>		d. STREET ADDRESS <u>83X-1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE MEARS SMITH</u>		4. DATE OF DEATH Month Day Year <u>JUNE 23 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 MAY 1873</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MESONGA, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Capt. ZADOCK S. MEARS</u>		14. MOTHER'S MAIDEN NAME <u>JULIE OTIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>0</u>	
17. INFORMANT <u>DAUGHTER (MRS. MILDRED WATERS)</u>		Address <u>239 Woodland Rd, Salisbury, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>DCARCINOMATOSIS with pulmonary, hepatic AND CEREBRAL METASTASES.</u> DUE TO <u>1977X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>—</u> DUE TO (c) <u>DCARCINOMA OF PANCREAS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 MOS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>APRIL</u> , 19 <u>60</u> , to <u>JUNE 23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>MAY 29</u> , 19 <u>60</u> , and that death occurred at <u>5:50 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>RUFUS S. GARDNER, JR.</u> M.D.		ADDRESS (Street, city or town, state) <u>PINEBLUFF RD.</u> DATE SIGNED <u>6/23/60</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>		<u>SALISBURY, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/25/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Smith Burying Ground</u>	22d. LOCATION (City, town, or county) (State) <u>Jenkins Bridge, VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Richard Johnson</u>		ADDRESS <u>Parkley, VA</u>	
24a. REC'D BY REGISTRAR <u>JUN 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dis. 03474

7482

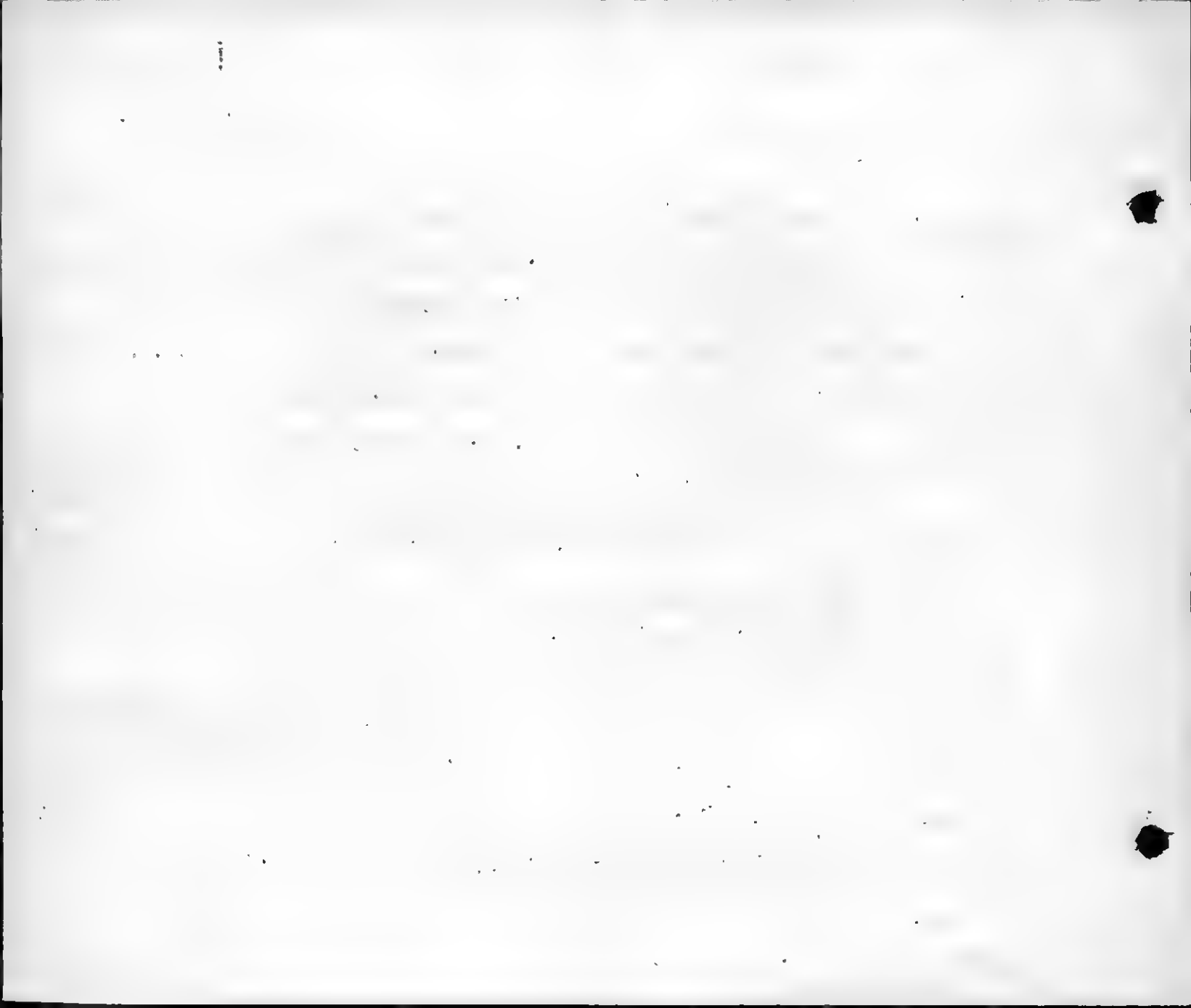
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>3 Wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WINIFRED ADKINS</u>		4. DATE OF DEATH <u>June 11 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24, 1888</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elijah Stanton Adkins</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Mae Truitt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Frank Adkins, Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Gau Neg. Rod. Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II (a) <u>Gau Neg. Rod. Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/15</u> , 19 <u>60</u> to <u>6/11</u> , 19 <u>60</u> that I last saw the deceased alive on <u>6/11</u> , 19 <u>60</u> , and that death occurred at <u>8:35</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Saunders M.D.</u>		ADDRESS (Street, city or town, state) <u>Nanticoke Md.</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>		DATE SIGNED <u>6/11/60</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-14-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Allen Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Allen, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 14 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles J. Howard</u>	

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

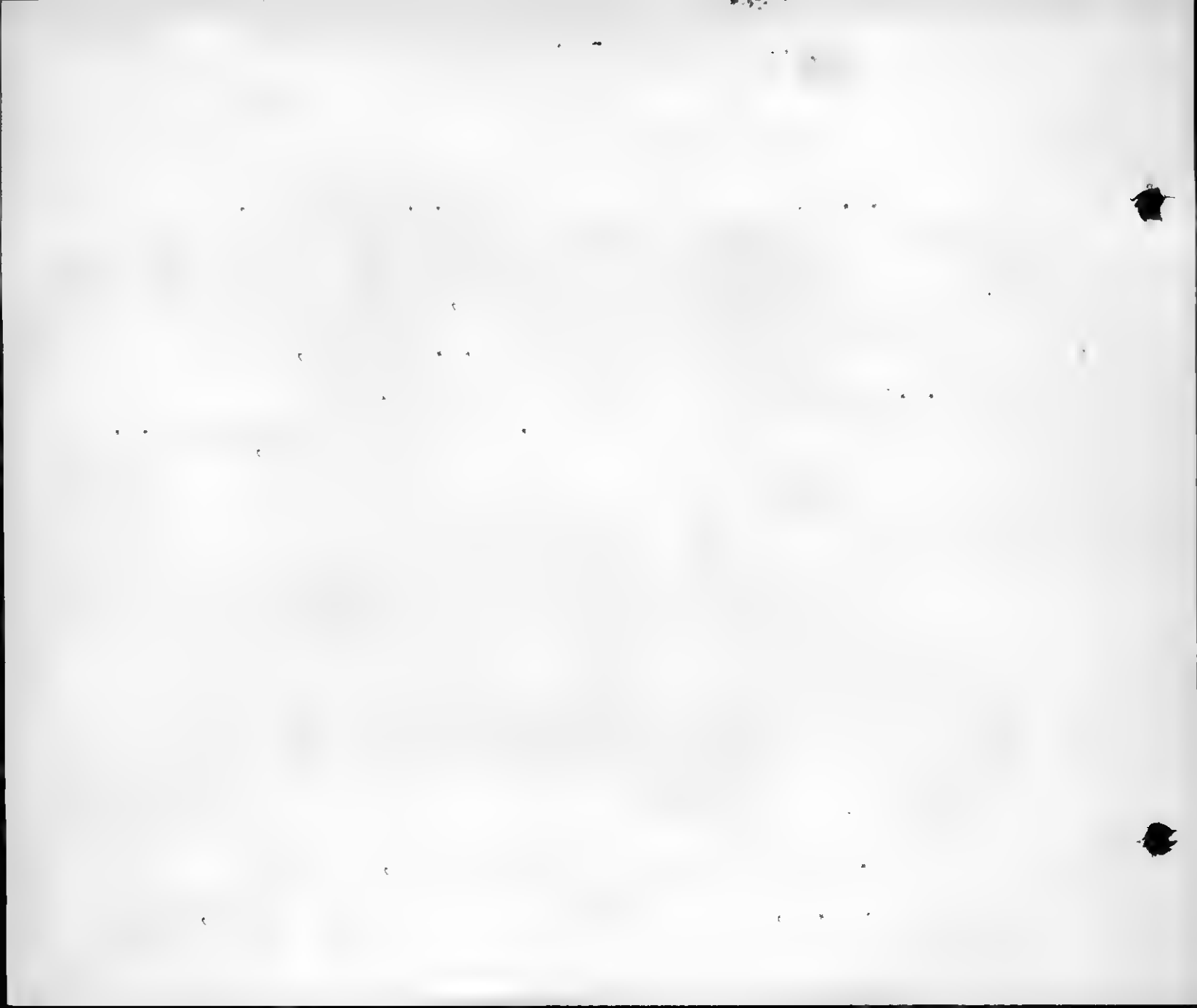
CERTIFICATE OF DEATH

7497

Item 8 11-11-60 0-2-00 01

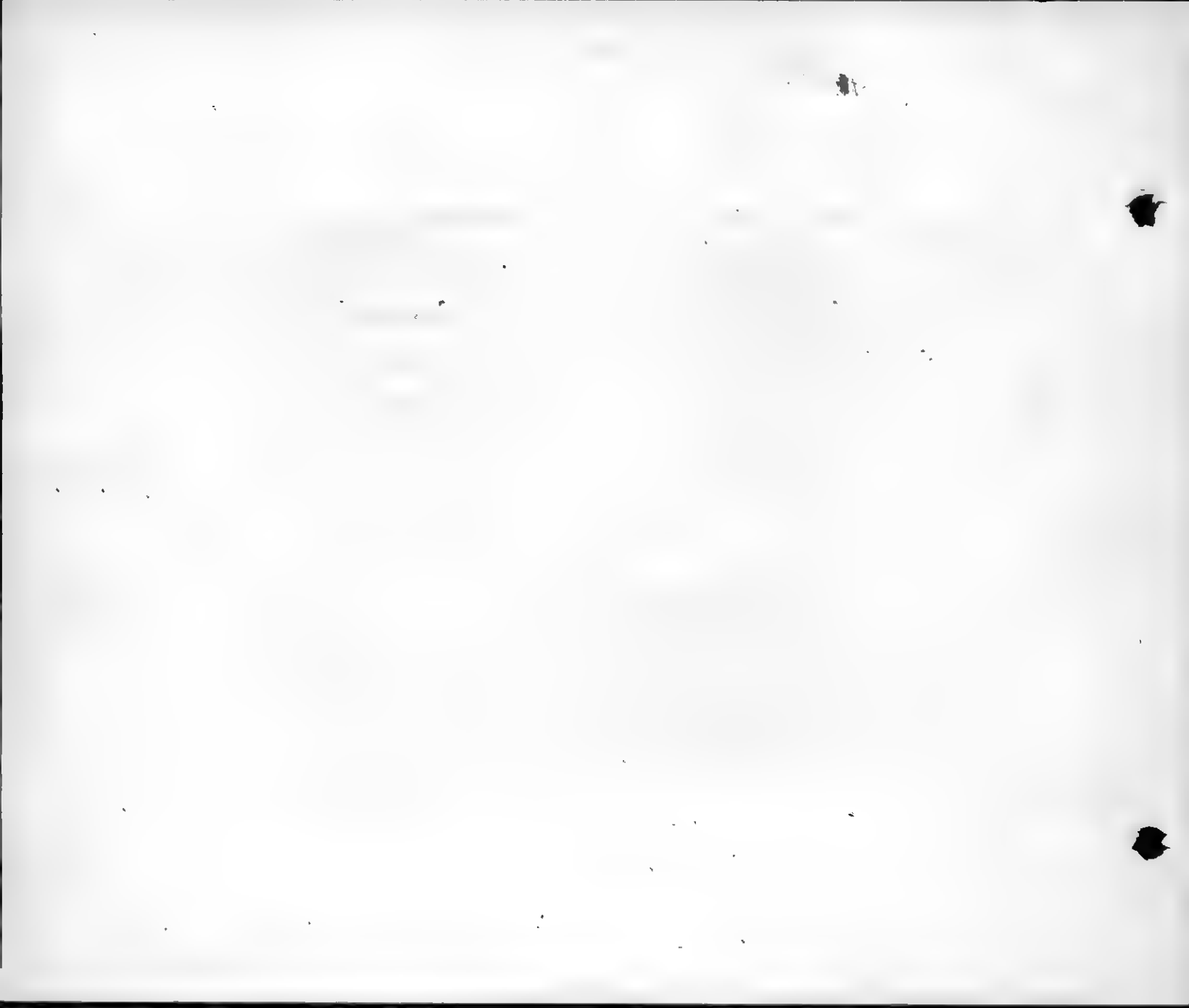
07475

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1</b>		d. STREET ADDRESS <b>R.D. # Union Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>FRANCIS</b> Last <b>TOADVINE</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>17th</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1886</b> <b>May 25, 1886</b>
9. AGE (In years last birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>22</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>R.D. Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Theo. F. Toadvine</b>		14. MOTHER'S MAIDEN NAME <b>Annie W. Hall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mrs. Mae Causey Toadvine (Wife) R.D.# 1 Union Rd Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332X</b> DUE TO <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cerebral thrombosis</b> DUE TO <b>generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 hours</b> <b>9 days</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>o m.</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <b>July 1955</b> to <b>June 1960</b> that (I) (we) last saw the deceased alive on <b>17 June 1960</b> and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert T. Adkins</b> M.D.		22b. DATE <b>June 20/1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert Adkins</b>		22d. ADDRESS <b>Fruitland, Maryland</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jun. 21, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		25a. REC'D BY REGISTRAR <b>JUN 21 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>



1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlantic</u> d. STREET ADDRESS <u>Atlantic</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Lee</u> Last <u>Tyndall</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1893</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>67</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Builder</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lee Tyndall</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Tyndall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>228-10-7439</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA LUNG</u> 103X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>103X</u> DUE TO (c) <u>103X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/25</u> , 19 <u>60</u> , to <u>6/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/18</u> , 19 <u>60</u> , and that death occurred at <u>10:22 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. B. [Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>MEDICAL CENTER</u> DATE SIGNED <u>6/18/1960</u>	
PHYSICIAN'S NAME (Type) <u>JOHN M. BLOOM</u>		<u>SALISBURY, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 20/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wattsville, Virginia Wattsville</u>	22d. LOCATION (City, town, or county) (State) <u>Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>For Funeral Home</u>		24. REC'D BY REGISTRAR <u>Charles S. Harris</u>	
25. DATE <u>JUN 27 '60</u>		26. REGISTRAR'S SIGNATURE	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07477

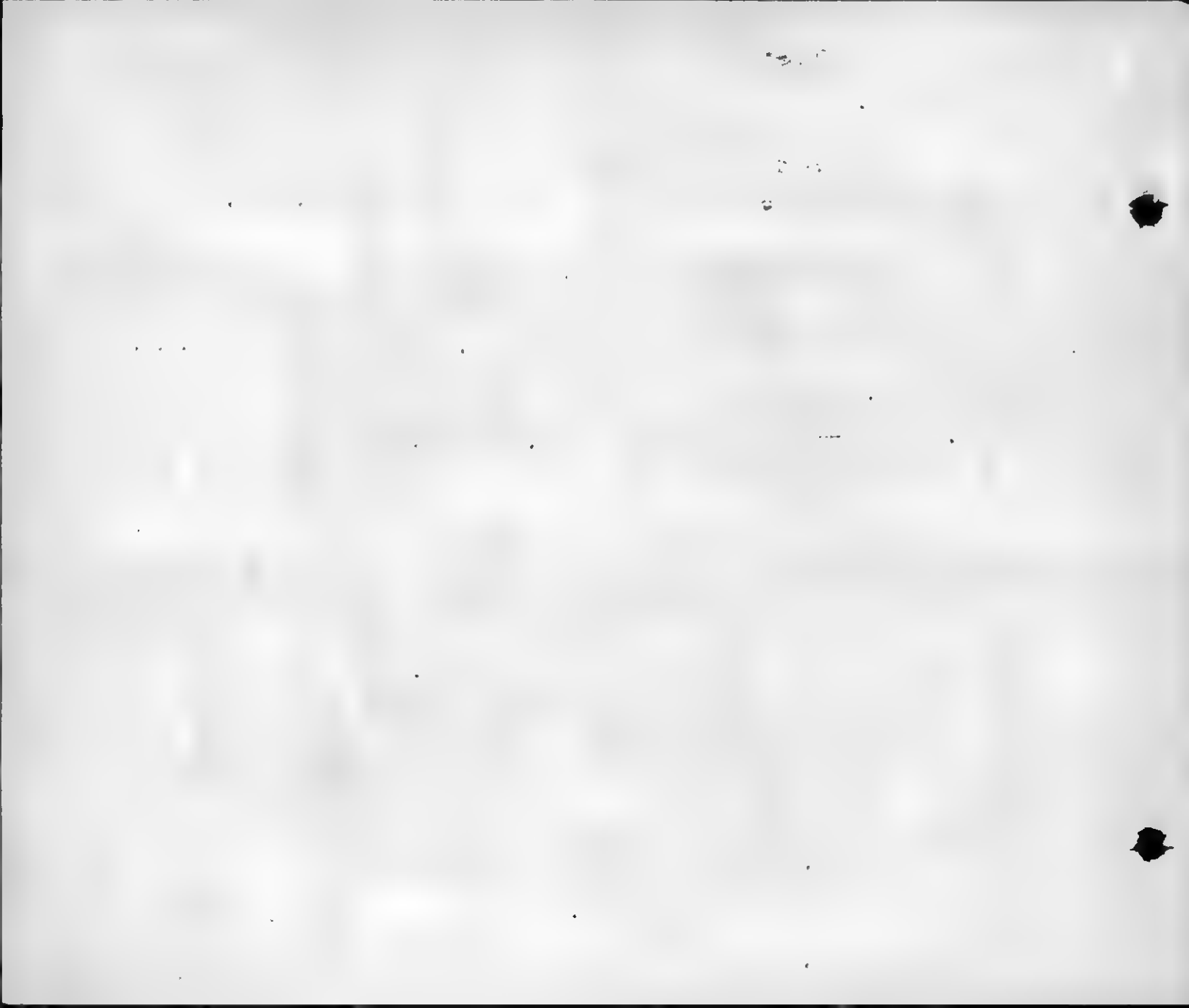
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY in lb <b>11 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>12 Camden Ave., Ext.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PATRICIA</b> Middle <b>ANNE</b> Last <b>VARLEY</b>				4. DATE OF DEATH Month <b>6</b> Day <b>22</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 3, 1949</b>		9. AGE (In years last birthday) <b>11</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert P. Varley</b>				14. MOTHER'S MAIDEN NAME <b>Beverly Nelson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. Robert P. Varley, Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronch pneumonia</b> <b>15</b> DUE TO <b>Fracture of Skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall from House</b>					
20c. TIME OF INJURY Month, Day, Year <b>2:15 a.m. 6-11 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Salisbury Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Earl L. Royer</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6-23-60</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/24/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE JUN 27 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

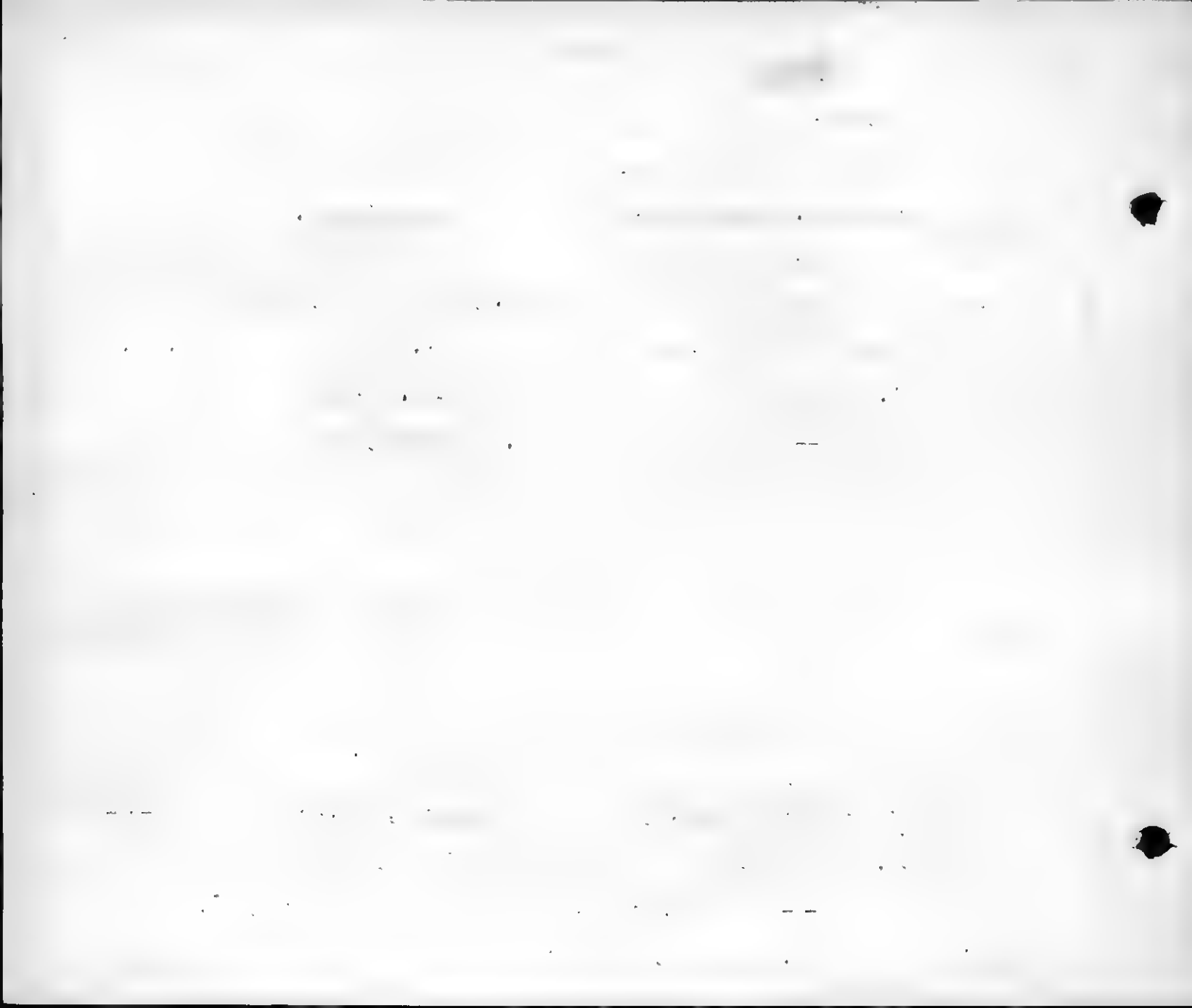
CERTIFICATE OF DEATH

Reg. Dist. No.

07475

7485

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN TB <b>5 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>425 Virginia Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>CARL</b> First Middle Last <b>EDWARD</b> <b>VAUGHN</b>		4. DATE OF DEATH Month Day Year <b>6</b> <b>3</b> <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1901</b>
9. AGE (In years last birthday) <b>58</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Floor Sanding</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	
11. BIRTHPLACE (State or foreign country) <b>Mich.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward L. Vaughn</b>		14. MOTHER'S MAIDEN NAME <b>Rosa A. Bates</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>Informant</b> <b>Mrs. Ray Vaughn, Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>156.1</b> IMMEDIATE CAUSE (a) <b>generalized Cancer</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cancer of Liver</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>22 months</b> <b>?</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>MAY 29, 1960</b> to <b>JUNE 3, 1960</b> that I last saw the deceased alive on <b>JUNE 3, 1960</b> , and that death occurred at <b>4:05 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert Adkins</b>		ADDRESS (Street, city or town, state) <b>Fruitland, Maryland</b> DATE SIGNED <b>6-4-60</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Robert Adkins</b>		<b>Fruitland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-5-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUN 6 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>



1. **FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

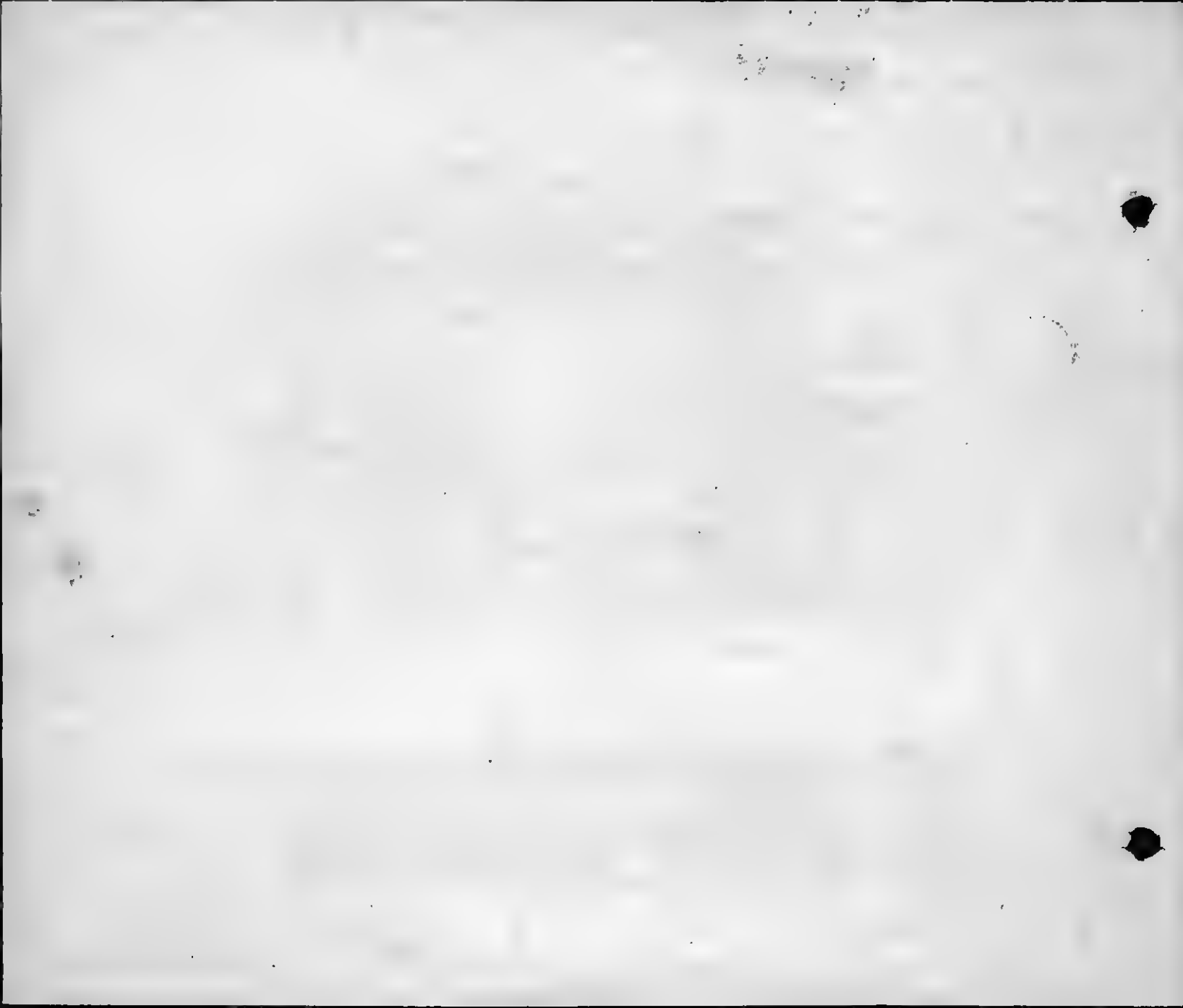
VS. A15ME  
SM 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07479

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hosp.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> d. STREET ADDRESS <u>Purnell Camp</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Nathaniel</u> First <u>Marion</u> Middle <u>Walker</u> Last		<b>4. DATE OF DEATH</b> <u>6-4</u> Month <u>1960</u> Day <u>19</u> Year	
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>C</u>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 1910</u>	
<b>9. AGE</b> (In years last birthday) <u>49</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>4</u> Days <u>4</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>North Carolina</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Andrew</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Hillie Walker</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <u>Louise Walker</u> Address <u>RFD. 2 Showell MD</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Chronic alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>Carl L. Boyer</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>EXAMINER'S NAME</b> (Type) <u>Carl L. Boyer</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>6-12-60</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore</u>		<b>22d. LOCATION</b> (City, town, or country) (State) <u>Baltimore N. Carolina</u>	
<b>23. FUNERAL DIRECTOR</b> <u>Clinton F. Stewart</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Arthur S. Thomas</u>	
<b>ADDRESS</b> <u>Baltimore</u>		<b>24b. REGISTRAR'S SIGNATURE</b>	

JUN 16 '60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

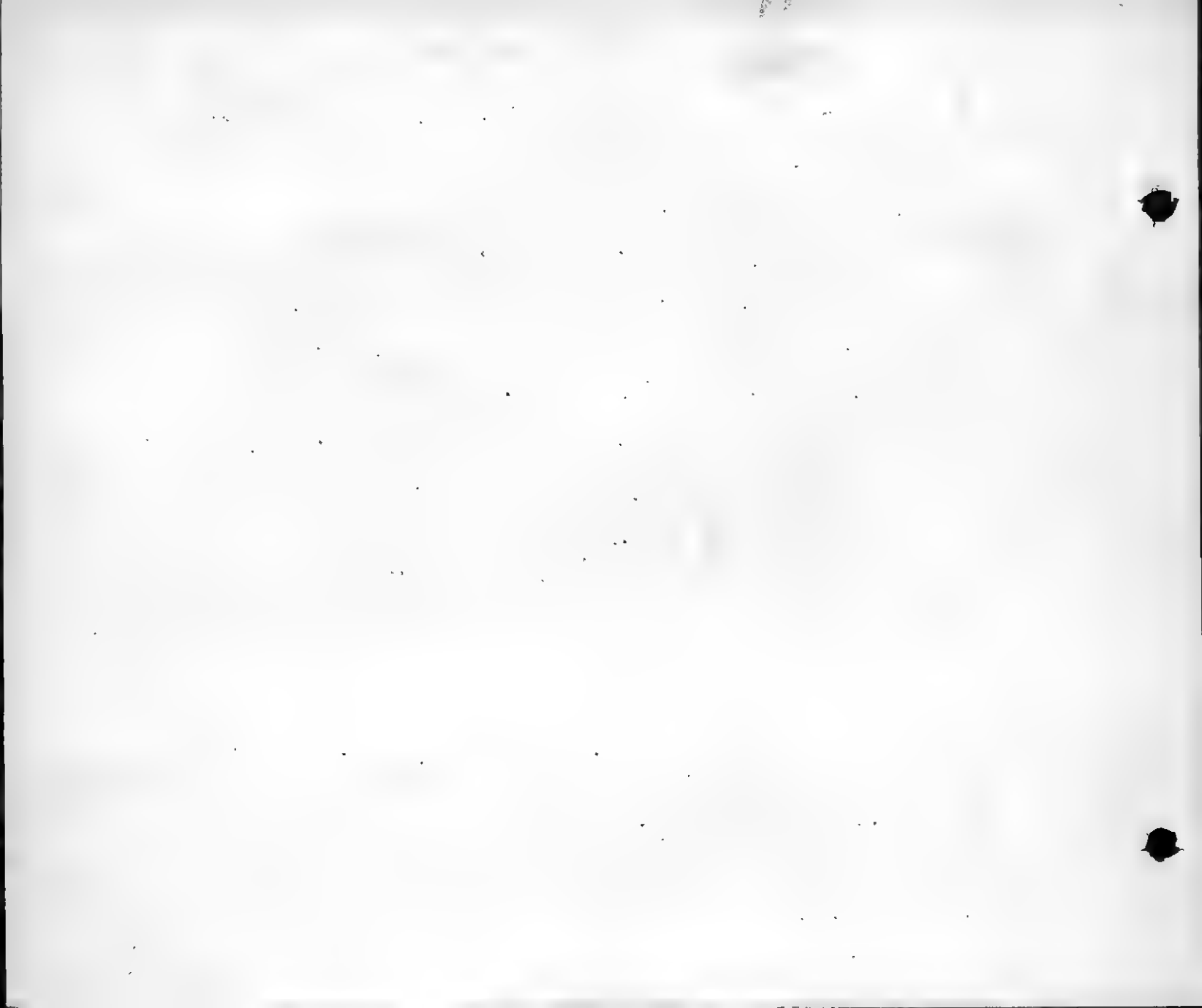
7487

CERTIFICATE OF DEATH

Reg. Dist. No.

07480

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>46X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mervin Barry Wharton</u>				4. DATE OF DEATH Month Day Year <u>June 2 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/25/1920</u>	9. AGE (In years last birthday) <u>40</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Wharton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lathbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>#2</u>				16. SOCIAL SECURITY NO. <u>22-07-8694</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Constrictive Pericarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Anemia</u> DUE TO (c) <u>Chronic Slow Nephritis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1 year</u> <u>20 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>August 1958</u> to <u>June 2, 1960</u> , that I last saw the deceased alive on <u>2 June 1960</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Joseph C. Fitzgerald</u> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MECHANICS COM.</u>		22d. LOCATION (City, town, or county) (State) <u>MILLSBORO D.P.I.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson &amp; Gray Millsboro, Del.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7488

## CERTIFICATE OF DEATH

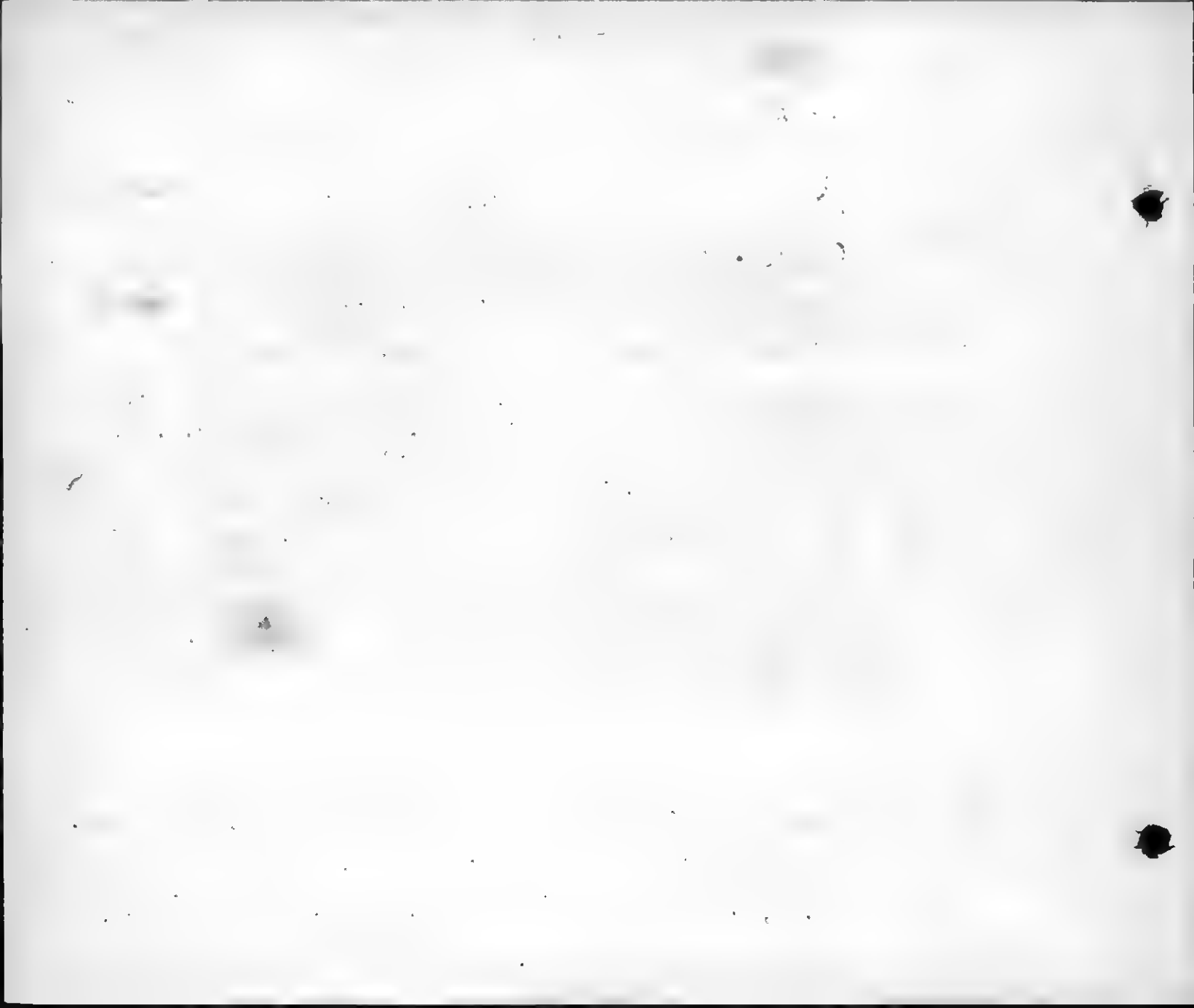
07481  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, give name of institution) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>ROUTE #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA-ELLEN-WHITE</u>		4. DATE OF DEATH Month Day Year <u>June 11-1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 21-1899</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Stockton, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Ambrose Townsend</u>	
14. MOTHER'S MAIDEN NAME <u>Laura Pruitt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <u>INFORMANT</u>		Address <u>Mr Herman L. White (Husband) R.D.# 1 Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>150X</u> <u>generalized carcinoma, lump</u> DUE TO (b) <u>Adenocarcinoma, Right Breast</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1959</u> to <u>June 11, 1960</u> , that I last saw the deceased alive on <u>June 11, 1960</u> , and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert T. Adkins</u> M.D.		ADDRESS (Street, city or town, state) <u>FRUITLAND, MARYLAND</u> DATE SIGNED <u>6/11/60</u>	
PHYSICIAN'S NAME (Type) <u>Dr Robert Adkins</u>		Fruitland, Maryland	
22a. BURIAL OR CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jun. 15, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SMULLEN CEMETERY-WORCESTER Co. M.D.</u>	
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>JUN 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

1  
22  
X  
I  
1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7489

## CERTIFICATE OF DEATH

Reg. Dist. No.

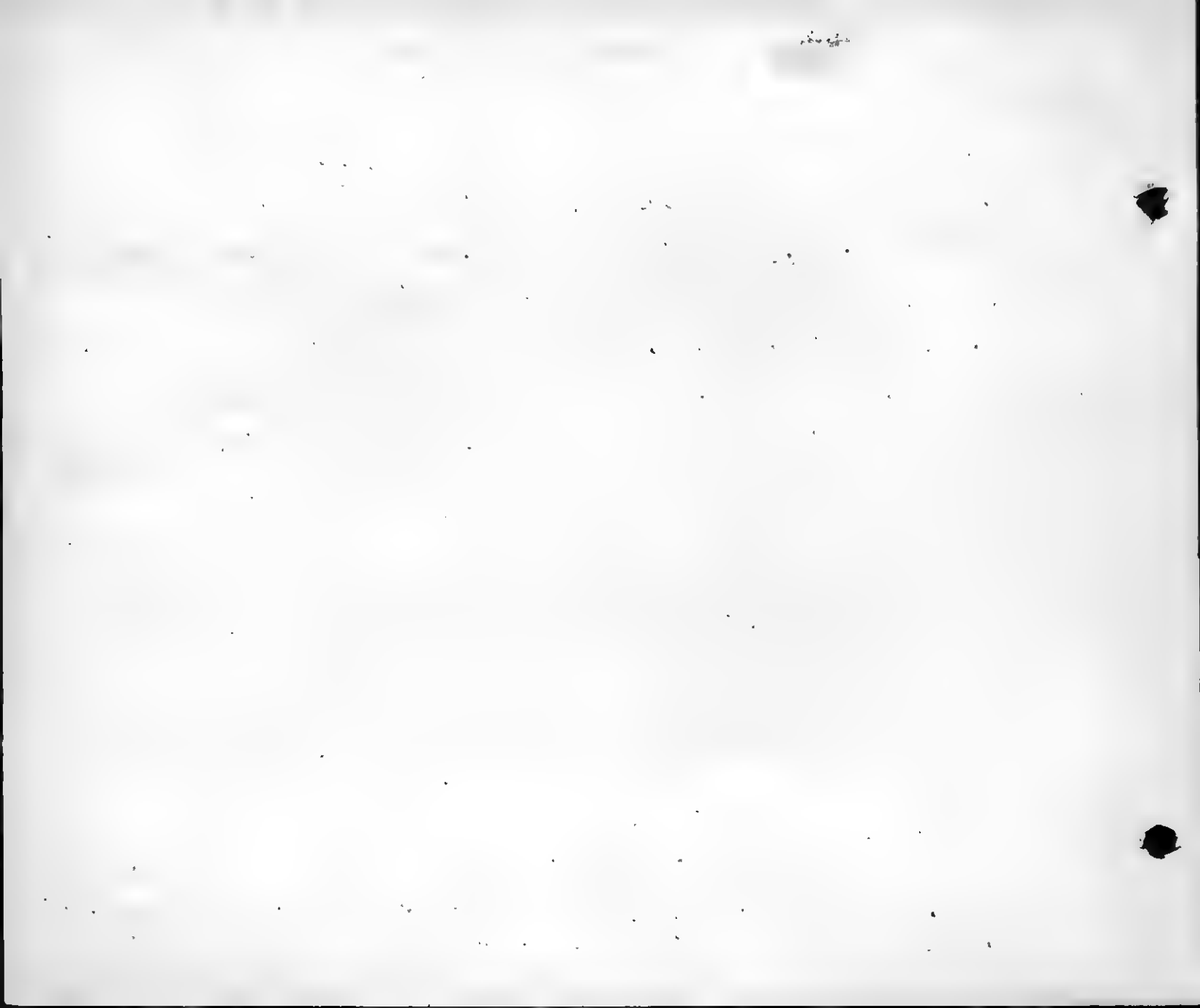
07482

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ESSIE MAE WHITE</u>		4. DATE OF DEATH Month Day Year <u>June 3 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 28, 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEWING MACH. OPER. PAINTS FACTORY</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>MITCHELL DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>ANNA HALL</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NO</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Postoperative Adhesions Stomach 23 years</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>15 March 1959</u> to <u>31 May 1960</u> that I last saw the deceased alive on <u>3 May 1960</u> and that death occurred at <u>1:40 PM</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Richard H Saunders</u> M.D.		DATE SIGNED <u>6/1/60</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD H SAUNDERS</u>		<u>NANTICKE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 3, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HEBRON CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>HEBRON MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas F. Wallace</u> ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATIS (4)  
ISM 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,8,9 & 10 Film G267 7/15/60 iwk

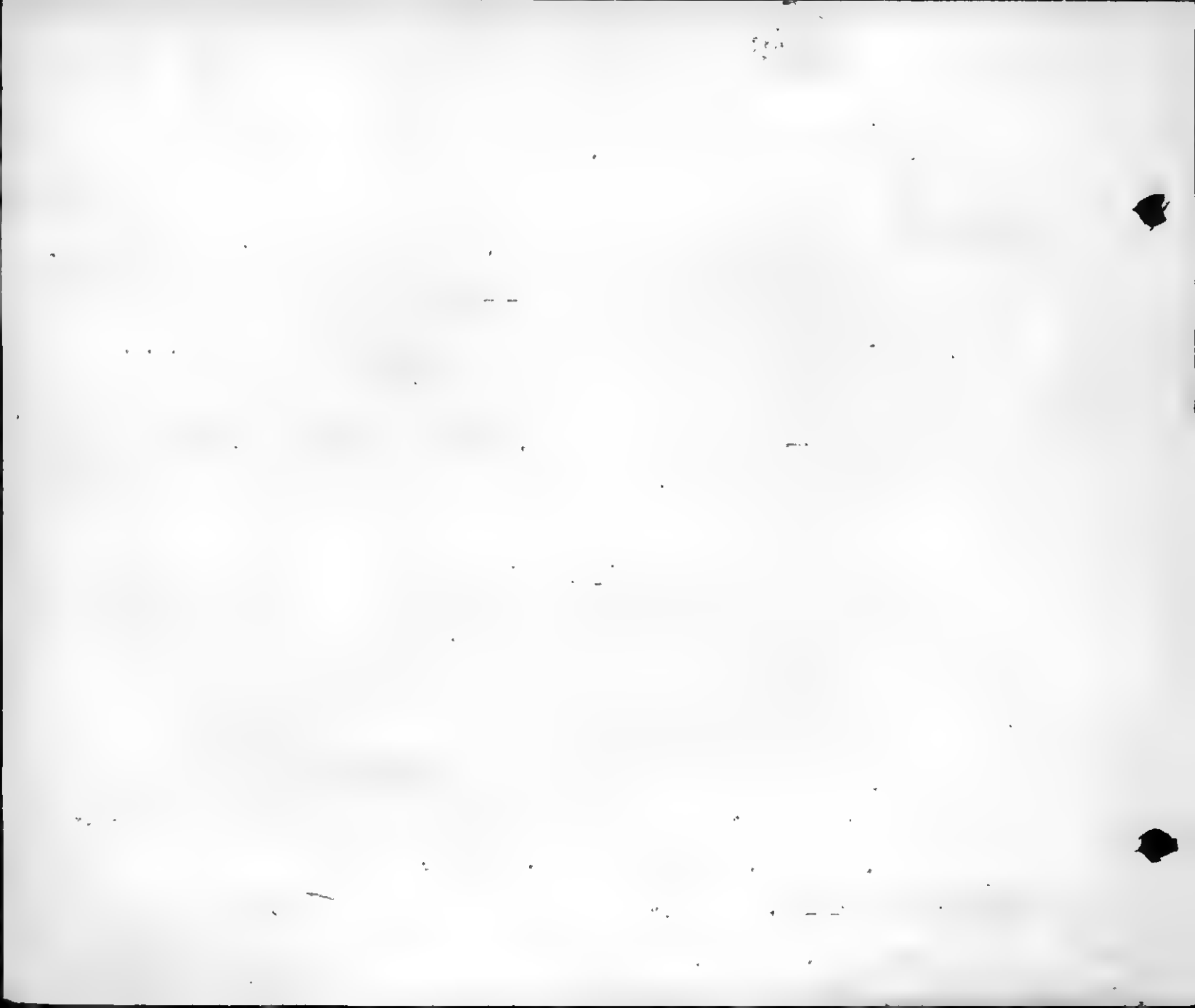
7498

## CERTIFICATE OF DEATH

Reg. Dist. No. 07483

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Wicomico</b> Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>				c. LENGTH OF STAY IN 1b <b>6 Mos.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt (Private home)</b>				d. STREET ADDRESS <b>1 Rt Towson, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EVA</b> Middle <b>MORRIS</b> Last <b>WHITE</b>		4. DATE OF DEATH Month <b>6</b> Day <b>29</b> Year <b>19 60</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-7-1872</b> 1873		9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife (Sales lady Own Home)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>M ryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>The odore Morris</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ward</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>188</b>		INFORMANT Address <b>Mrs. Paul Phillips, Towson, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) <b>Cerebral arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>+ 2 days</b> <b>?</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>arteriosclerotic heart dis.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/20</b> , 19 <b>60</b> , to <b>death</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6/29</b> , 19 <b>60</b> , and that death occurred at <b>9:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Delmar, Delaware</b> DATE SIGNED <b>6-30-60</b>							
ACTUAL SIGNATURE <b>Ernest M. Lammore</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. Ernest M. Lammore Grove St., Delmar, Delaware</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-1-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Thoma</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A11 (4)  
15M 9/59

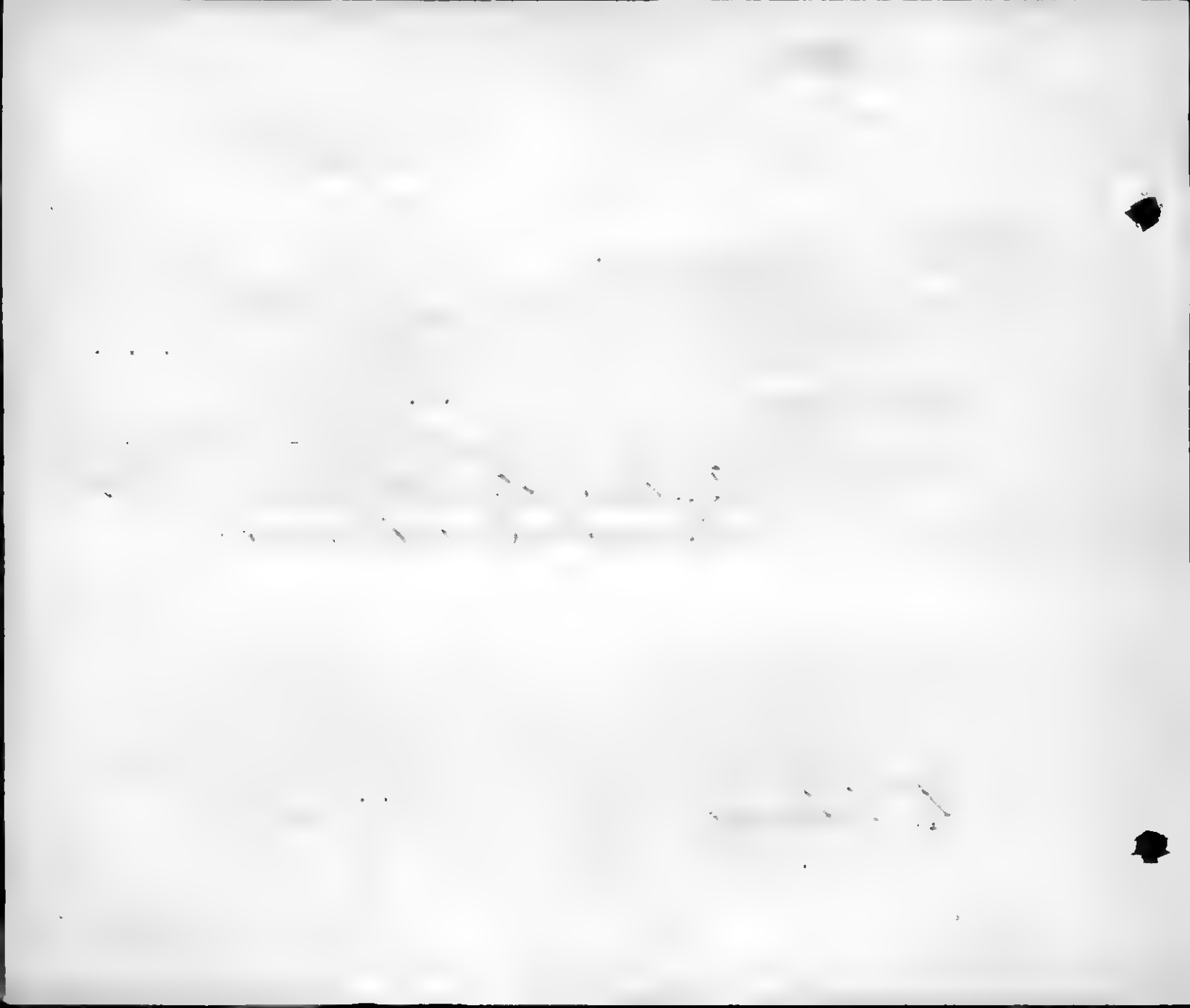
1  
M  
091

7490

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07484

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>Princess Anne</b> <b>Route 3</b> <b>19X-</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>E.</b> Last <b>White</b>		4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1868</b>
9. AGE (In years last birthday) <b>92 yrs</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lettleton</b> <b>John Bloodsworth</b>		14. MOTHER'S MAIDEN NAME <b>Lucretia</b> <b>L. Murell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records -- Salisbury, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis 20 yrs</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/23/1960</b> to <b>6/4/1960</b> , that (I) (we) last saw the deceased alive on <b>6/4/1960</b> , and that death occurred at <b>1:20</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee L. Lawry</b>		22b. DATE SIGNED <b>June 4, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, MD</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/7/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Andrews</b>		23d. LOCATION (City, town, or county) (State) <b>Princess Anne Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James Hunner</b>		25a. REC'D BY REGISTRAR <b>Princess Anne</b> DATE <b>JUN 7 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7499

CERTIFICATE OF DEATH

Reg. Dist. No.

07485

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharptown - Rural</b>				c. LENGTH OF STAY IN 1b <b>17 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maple Shade Convalescent Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martina</b> Middle <b>Willey</b> Last <b>Willey</b>				4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 28, 1871</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min.	IF UNDER 24 HRS. Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elisha Andrew</b>				14. MOTHER'S MAIDEN NAME <b>Mary Nichols</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Mrs. James H. Knox, Denton, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>General Arterio Sclerosis</b> DUE TO (c) <b>Viral Respiratory Infection</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>2</b> <b>\$ weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 7, 1960</b> , to <b>June 24, 1960</b> , that I last saw the deceased alive on <b>June 24, 1960</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. S. Kufman</b>		M.D.		ADDRESS (Street, city or town, state) <b>Sharptown, Md</b>		DATE SIGNED <b>6/27/60</b>	
PHYSICIAN'S NAME (Type) <b>H. S. Kufman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 27, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 30 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knox</b>	

10

10



1  
 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 7500 CERTIFICATE OF DEATH

07486

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>H.D.# 4 (Parker Rd.)</b>		d. STREET ADDRESS <b>R.D.# 4 (Parker Rd)</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>JANE</b> Middle <b>WONDERLY (WONDERLICH)</b> Last		4. DATE <b>JUNE</b> Month <b>18th</b> Day <b>19</b> Year <b>60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1870</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Fulton County Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>(Unk) Evertt</b>		14. MOTHER'S MAIDEN NAME <b>No Record</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr Orman L. Sherman (Son)</b> Address <b>108 Talbot St Easton, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>422.2</b> IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO <b>degenerative heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days 5 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 6 1956</b> to <b>6/18 1960</b> , that (I) (we) last saw the deceased alive on <b>6/17 1960</b> , and that death occurred at <b>9:45 A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Earl Beardsley</b>		22b. DATE SIGNED <b>June 20 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl Beardsley</b>		22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jun. 22, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		25a. REC'D BY REGISTRAR <b>JUN 21 '60</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

7500

COMMUNICATIONS SECTION

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54

11/1/54